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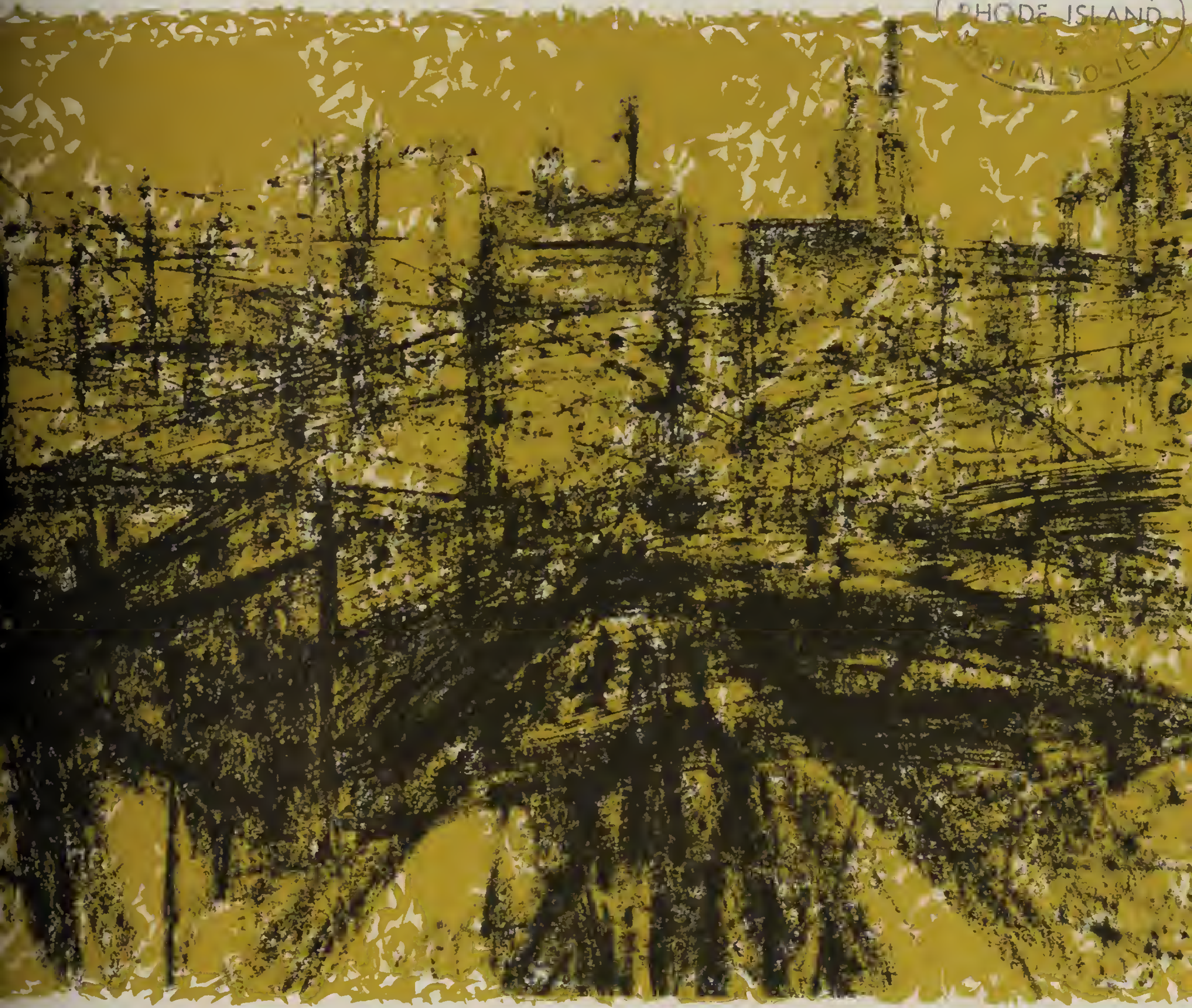

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MICHIGAN STATE MEDICAL
SOCIETY JOURNAL
VOLUME 67, NUMBER 15
AUGUST 1968

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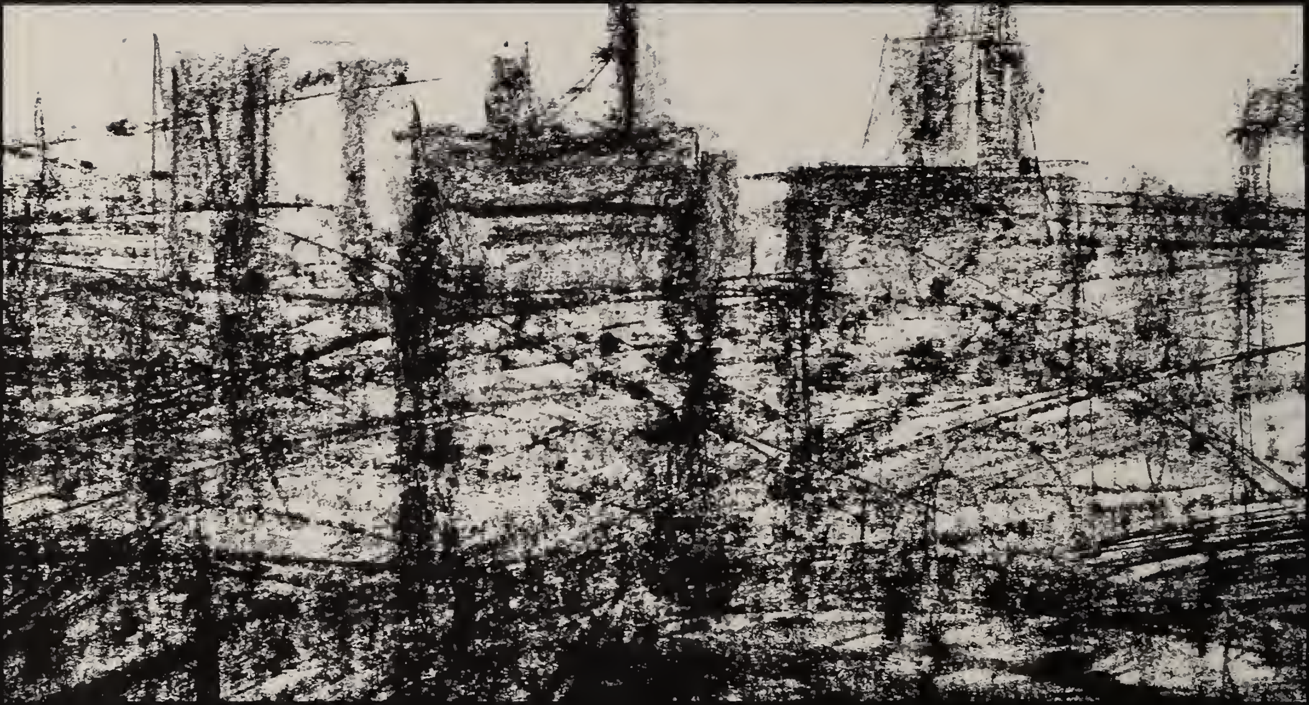

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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THE COVER

The art work on the cover is a charcoal sketch "Cityscape" by Mrs. Clara Rogers of Birmingham. It is being used in all the MSMS promotional efforts for the 1968 Annual Session to be held in Detroit, September 25-26. Mrs. Rogers works in many media and has had many works on exhibit in Detroit and other cities.

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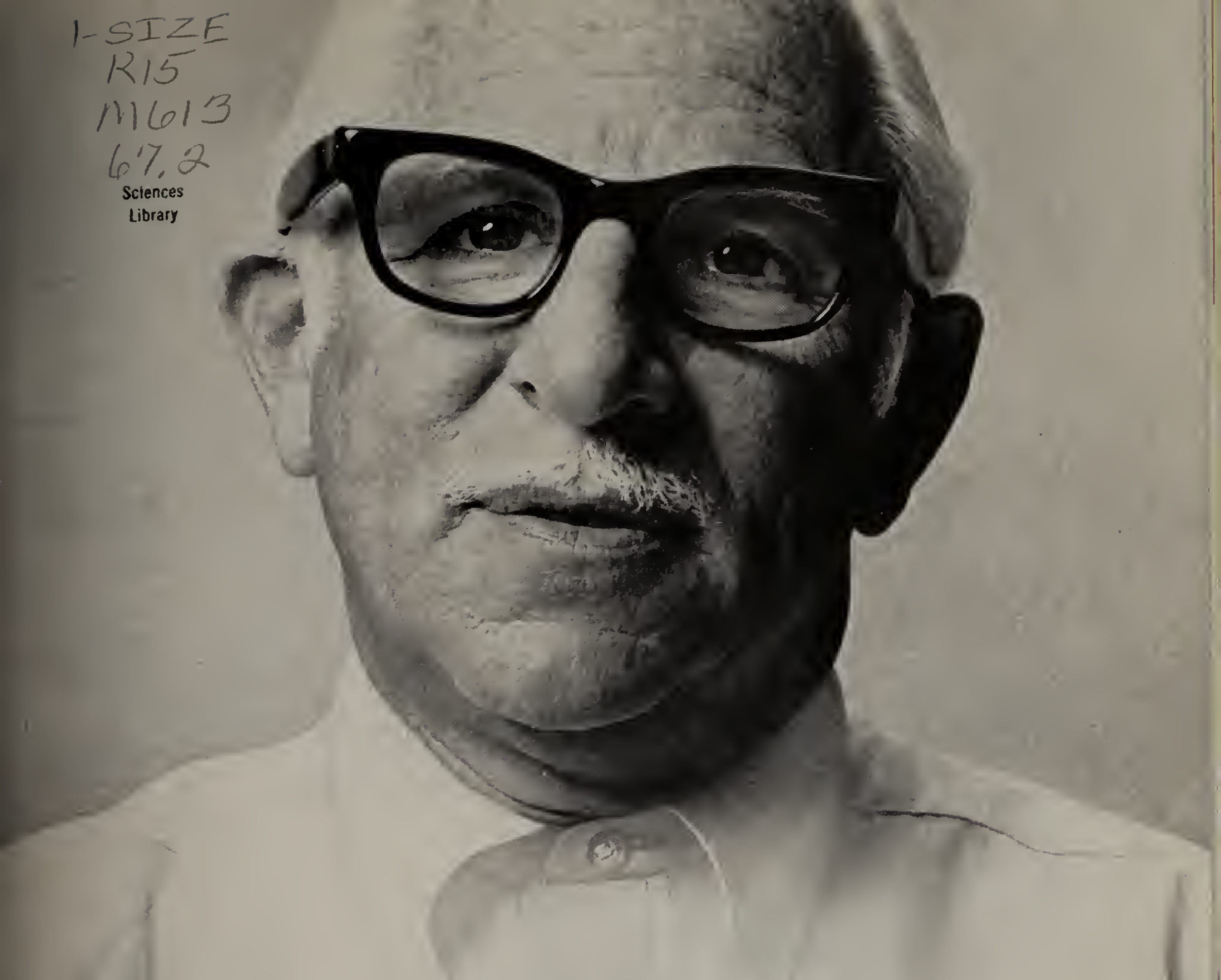

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

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BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Community Health Week Offers Three Targets

Most Americans today are living longer, healthier, more active and useful lives than in any period of our nation's history.

Many factors are contributing to our healthier lives such as the important achievements of modern medicine in the past few decades, community efforts in providing modern hospitals, public awareness of good health practices, and significant contributions to medical progress that are being made by medical scientists world-wide.

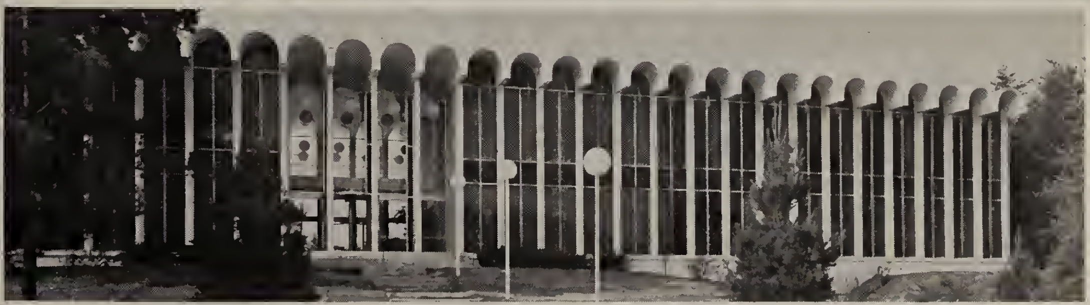
The purpose of Community Health Week (October 20-26) will be to focus public attention on the dramatic advances which have occurred in medicine and health care. The Annual Community Health Week project is proclaimed by the AMA and MSMS to encourage each of us to stimulate a greater public understanding of the growth, high quality and availability of health resources and facilities within the individual community.

In addition to an evaluation of our present assets, the 1968 Community Health Week this fall will focus attention upon (1) the growing problem of drug abuse, (2) the need to encourage and support the programs encompassing physical fitness, and (3) the expanding, urgent need for young men and women to train for medical and allied health careers. A career in medicine or any of its allied fields offers a challenging and rewarding future. You can help by encouraging capable young people to prepare for careers in health.

Each county society is urged to organize a health careers recruitment program. Doctors can speak to school assemblies, can consult with school counselors, can cooperate with the medical auxiliary and voluntary agencies, and can ask ahead for a visitation of the Michigan Health Council's health careers mobile.

As in other years, the Michigan Health Council and the Michigan Association of the Professions will jointly sponsor Community Health Week with MSMS.

All county medical societies are urged to develop appropriate programs marking the annual observance of Community Health Week, October 20-26 and to encourage other members of the community health team to join with them in planning and carrying out activities.



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Generally, withdrawal bleeding is comparable to her usual menstrual flow, even after prolonged use. Incidence of amenorrhea was less than 1% in original studies. Breakthrough bleeding occurred in only 1.5% of full cycles completed, and intractable monilial vaginitis was not reported.

Patients can continue ORACON comfortably. For years. Although a cause and effect relationship has been neither established nor disproved, alertness to the possibility of serious occurrences such as thromboembolism is necessary in any program with any oral contraceptive. Contraindications, medical ramifications, and long-range considerations in the use of ORACON, the same as those for all oral contraceptives, follow.

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Contraindications: Thrombophlebitis, history of thrombophlebitis or pulmonary embolism; liver dysfunction or disease; known or suspected carcinoma of breast or genital organs; undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. Since the safety of ORACON in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions: The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by treatment with ORACON. Therefore, if such tests are abnormal in a patient taking ORACON, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of estrogen-progestogen preparations, pre-existing uterine fibromyomata may increase in size. Because these agents may cause some degree of fluid retention, conditions that might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. ORACON should be used with caution in patients with a history of cerebrovascular accident. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged ORACON therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving ORACON therapy. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. Because of the effects of estrogens on epiphyseal closure, ORACON should be used judiciously in young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with ORACON may mask the onset of the climacteric. The pathologist should be advised of ORACON therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been

continued on next page

observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post-partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following have been reported as side effects in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. Post-marketing experience with ORACON has revealed that hypermenorrhea and acne may also occur. The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has neither been established nor disproved: thrombophlebitis, pulmonary embolism, neuro-ocular lesions. The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests; coagulation tests (increase in prothrombin, Factors VII, VIII, IX, and X); thyroid function (increase in PBI and butanol extractable protein bound iodine and decrease in T^3 values); metyrapone test; pregnanediol determination.

Administration: Counting onset of menses as Day 1, the patient starts medication on Day 5 of the cycle and takes one white tablet daily from Day 5 through Day 20, then one pink tablet daily from Day 21 through Day 25. Patients should be cautioned to follow the dosage schedule strictly. Evening administration is suggested. An additional contraceptive method is recommended for the first 7 tablet days of the first cycle of ORACON usage. If the regimen is interrupted, for the fullest possible protection an additional contraceptive method is recommended for the rest of the cycle. If flow should not occur by the 7th day after taking the last pink tablet, the next course of therapy should be initiated on that day, thereby allowing 6 full days without medication. Some physicians prefer to stipulate that the patient never allow more than 6 unmedicated days to elapse between cycles regardless of the time of onset of withdrawal bleeding. If two consecutive periods are missed, the possibility of pregnancy should be considered and the patient should report to the physician. However, pregnancy should be suspected at the first missed period if the patient has deviated from instructions. For those few occasions when breakthrough bleeding occurs, the following recommendations are made: (a) Spotting. Continue medication. (b) Menstrual-type flow. Discontinue medication and begin a new medication cycle on the fifth day. Because of the rarity of frank breakthrough bleeding, especially after the first few cycles, it is not necessary to provide the patient with additional tablets to allow for doubling the dose. Recurring breakthrough bleeding, particularly after the first few cycles, should be reported to the physician for further investigation. Because of the common occurrence of increased cervical mucus, it is recommended that the patient be apprised of this possibility.

Availability: ORACON is available as 16 white and 5 pink tablets. Each white tablet contains 0.1 mg. of ethinyl estradiol; each pink tablet contains 25 mg. of dimethisterone and 0.1 mg. of ethinyl estradiol. Each month's supply includes patient instructions. Complete details on ORACON are available from Mead Johnson Laboratories.

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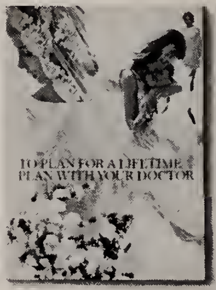

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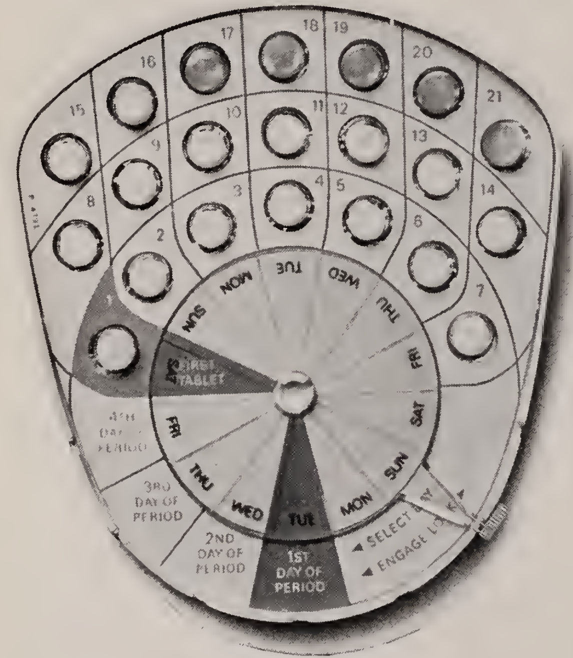

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Where Are We Heading?

BY J. H. AHRONHEIM, M.D.
JACKSON

(Note: This editorial first appeared in a recent issue of the Foote Hospital Pathological News Bulletin and is reprinted with permission of Doctor Ahronheim, who is also the editor. BLM)

According to recent reports in the press, the American Medical Association is considering steps designed to improve emergency care. This report does not exactly spell out what is meant by emergency care; it may be the attempt to relieve the pressure on hospital staff members in covering emergency service, or it may be to provide prompter service to those patients who are trying desperately and not too successfully to get a doctor's appointment, or it may be both.

Whichever it may be, the AMA is aware of a problem which is becoming increasingly more serious, and of which there is little hope in sight that it will improve. It is nationwide and is certainly felt more and more in our own community. An aging medical profession is losing more members by death and retirement than are being replaced by the slow influx of young men; the remaining practitioners are overworked and unable to take on more of a work load, physically and time-wise.

TO COMPLICATE THINGS even more, medicine is becoming more complex and there is greater demand for highly specialized diagnostic and therapeutic procedures than ever before. Medical practice is becoming a practice of specialties and the institution of family physician and general practitioner is slowly becoming a matter of the past. Today, we are no more satisfied with the patients' care which was considered standard 50 and even 25 years ago. To be rated a reasonably good physician, one must be certified by all sorts of professional bodies. Hospitals don't count anymore unless they are accredited by an increasing number of hospital organizations. Every person who has some connection with the practice of the healing arts needs now a license for whatever he is trained to do. Training and more training is emphasized. We are trying to make nurses out of aides, doctors out of nurses and university professors out of practitioners.

Obviously, all this is done to upgrade medical practice and has undoubtedly contributed to making American medical science the leader in the world. But it still does not take care of the one problem which is facing the entire nation: giving John Doe the care which he needs and when he needs it. Patients seeking a doctor's appointment often have to wait weeks before an available spot is found for them on the physician's schedule. The doctors do their utmost to meet the medical demands of the community, but there are still only 24 hours in a day, and coronary arteries can take only that much.

WHAT ARE WE GOING to do about this situation?

If there were a simple answer to this question, I am sure, it would have already been given by those who have studied the problem. Yet, let's think about it for a while and let's do a bit of speculating. Perhaps we might get some ideas from past experiences of our profession. Let us go back, for example, to the times, not too far removed, when a physician had his own little laboratory in the back of his office where he performed the simple tests which were known then, urinalysis, blood counts, occult blood determinations, and a few others which may or may not be obsolete today. When more tests were developed and laboratory medicine became more complex and sophisticated, the doctor needed a helper, an assistant, a technician. Usually it was his nurse or office girl whom he would teach the few tests which he was able to do. Later schools would be established for the purpose of turning out trained laboratory technicians. Thus, the fine profession of the medical technologist evolved.

Similarly, other phases of the practice of medicine, once the sole prerogative of the physician, would be delegated to specially trained personnel, and the professions of the physiotherapist, the dietitian, the anesthetist, and a few others were developed. They would work under the supervision of the physician and relieve him of many time consuming duties. I could well see that we carry this trend further yet. I could envision technicians for other phases of the practice of medicine by which a person would be trained solely for one specific phase, such as taking care of emergency cases, doing house calls for pediatric and obstetrical cases (there was nothing wrong with midwives who, in the past, had taken care of confinement cases most efficiently), making emergency

(Continued on Page 943)

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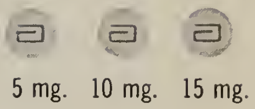

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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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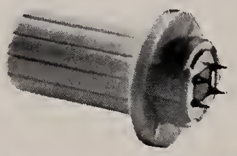

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decisions until the physician could take over. The physician, under whom these technicians would work, would be responsible for the technician's actions. The training would have to concentrate not only on making the student acquainted with his duties but, perhaps even more so, on making him aware of his limitations.

YOU MAY SAY that there are serious objections to this sort of medical practice by technicians. You may argue that the patient who calls a doctor, wants to be seen by a doctor and not by a technician. But let us ask the same patient if he would rather suffer for hours until the doctor finally shows up or would settle on a specially trained person who would give him the desired relief until the doctor can take over. You may say that this type of practice violates the law pertaining to the practice of medicine. Maybe so, but, if need be, laws can be changed and this type of nonphysician assistant could develop into a well recognized profession sanctioned by law. You may argue that technician practice may impair the quality of the practice of medicine.

As long as the technician works under the doctor's strictest supervision, this is a very remote possibility, in fact, it may even improve medical practice, just as the profession of the medical technologist has improved medicine.

Whatever our objections may be, we have to face facts and have to compromise somewhere and sometime. If we don't, the medical profession will some day consist of long-haired super-scientists whose minds are perpetually in the clouds while the patients suffer from the common cold and perforated appendices.

LET'S FACE IT, the public is already getting mighty impatient with us. When a patient is miserable, he is not concerned about a doctor's tight schedule, or the rest which he didn't get last night, or the coronaries which threaten to close up on him. He wants relief and he wants it now.

Probably, things are not quite as critical as that yet, but the day will come when we have to make decisions if we want to live up to the principles to which we pledged ourselves when we recited the oath of Hippocrates. ☐

At Your Service

BY BROOKER L. MASTERS, M.D.
CHAIRMAN PUBLICATION COMMITTEE

Whether you work 9, 10 or 12 hours a day, you know there is one thing which can't be stretched — time!

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Why not get the habit of reading *Michigan Medicine* regularly to win your struggle for more time? The articles are crisply written, tightly edited, neatly arranged on the pages, and then printed and mailed as quickly as possible.

At your service.

Paradox of the Medical World

BY JOHN H. VAN DE LEUV, M.D.
OXFORD, MICHIGAN

(Note: This article is reprinted with the permission of the author and the Oakland County Medical Society Bulletin, which carried this item in a recent issue. BLM)

Physicians, in their practice, often deal with urgent if not emergent problems. Immediate decisions and fast action are indicated. On the whole, we do very well in this aspect of our professional lives.

We are, with the exception, perhaps, of professional writers, the most prolific penpushers in the world. We as a group talk more than any other profession apart from politicians and, possibly lawyers.

UNFORTUNATELY, MOST OF the writing and talking is directed at our colleagues. By and large we, as individuals and groups, do very little to make our opinions known to "the public." We seem to want to hide in our shells when it comes to expressing our views in the regular news media. We seem to shun publicity except when it is forced upon us, when we are approached on a specific topic. We tend to hide behind our code of ethics as if it were a bombastic barrier between us and the non-initiated.

Why is it that we do not write more letters to editors, to our representatives? Why don't we publish more articles in the "lay" papers? Why don't we circulate any petitions? With the possible exception of the TV programs, we, probably, have the largest audience in the USA. If every physician — or, let us say, half of the physicians in the USA — convinced three patients per day of our stand on certain important social, political or economical questions, we would reach about half a million persons daily, that is almost all of the population in the United States in less than a year!

ARE WE TOO BUSY to let ourselves be known? Don't we have the medical societies to take care of this aspect? Can we be bothered by these nonmedical issues? Who would listen to us anyway; haven't we lost most of our prestige in society in the last few decades?

The answers are that the medical societies can never take the place of personally expressed opinions. People are getting tired of hearing the AMA declare its stand — that doctor's UNION is only after more money for the medical profession anyway! But they may sit up and pay attention to an expression of opinion of their "own doctor." Are we too busy? One would think not, when we can spend part of an evening in a meaningless hospital staff meeting, when we can find time to serve on two, three or more committees. Why should we be bothered by these non-medical issues? Because we are first of all citizens and, as such, have to make sure that our society is in tiptop shape (meaning society in the broadest sense possible).

COULD IT BE THAT we are after our own welfare alone and the rest of the populace be damned? This seems to be the attitude that we assume in the eyes of many. And justifiably so.

What then can we do? For a starter, we can get more involved in local, political and educational matters. We can let our representatives know what we think about pending legislation, not as a group but individually. We can urge more action on pressing problems and keep harping on these. It would not hurt to publicize the fact that we work three to five months each year for our good Uncle Sam, before we start paying our nurse's wages and the rest of our overhead, that we spend hours and hours in meetings that have the welfare of the community, directly or indirectly at heart.

But, for Heaven's sake, let people, your patients, hear from us! ☐

HUBBARD DISCUSSES PATIENT'S RIGHT TO DIE

The right of a patient to die may, in some cases, supersede the right of a physician to attempt to further his life by operations such as heart transplants, said William N. Hubbard, M.D., dean of the University of Michigan Medical School, in a recent address to the graduating class at the Albany Medical College of Union University in New York.

"To sacrifice human dignity at the time of death or to make the process of dying a burden upon the living is not in the highest tradition of medicine nor is it justified in the humanist traditions," said Doctor Hubbard.

"The humane physician must learn to understand and accept death as an inevitable part of living. He must beware of treating his own anxiety that death represents his personal failure by unrestrained use of life-support systems," the medical dean continued. ☐

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Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

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effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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for moderate to severe anxiety and mixed anxiety-depression

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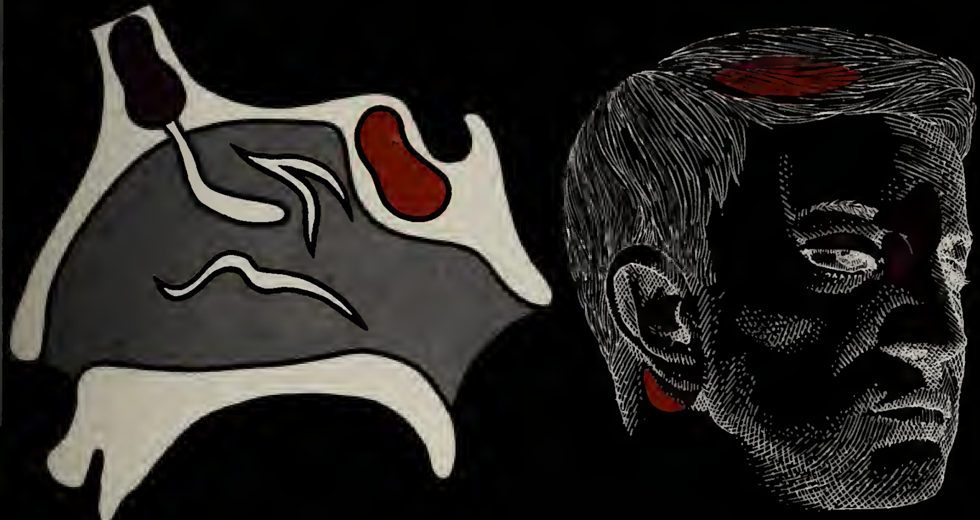
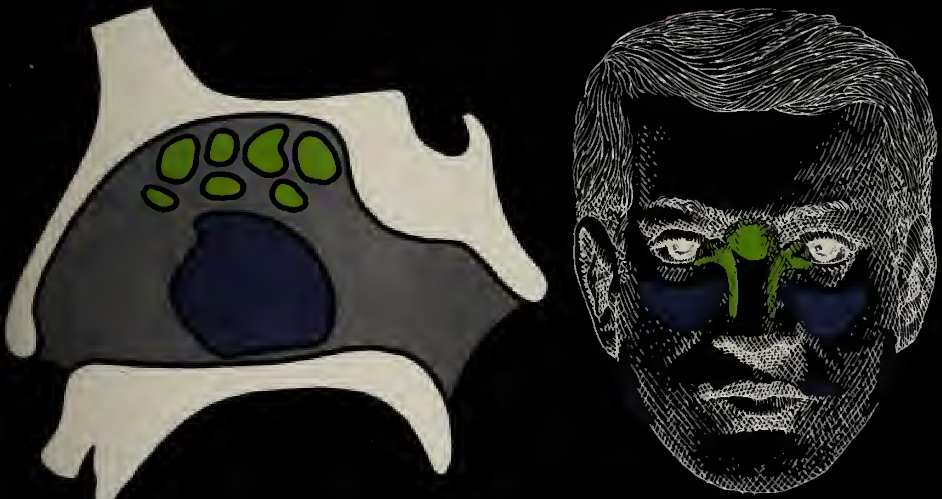
Sources of sinus headache

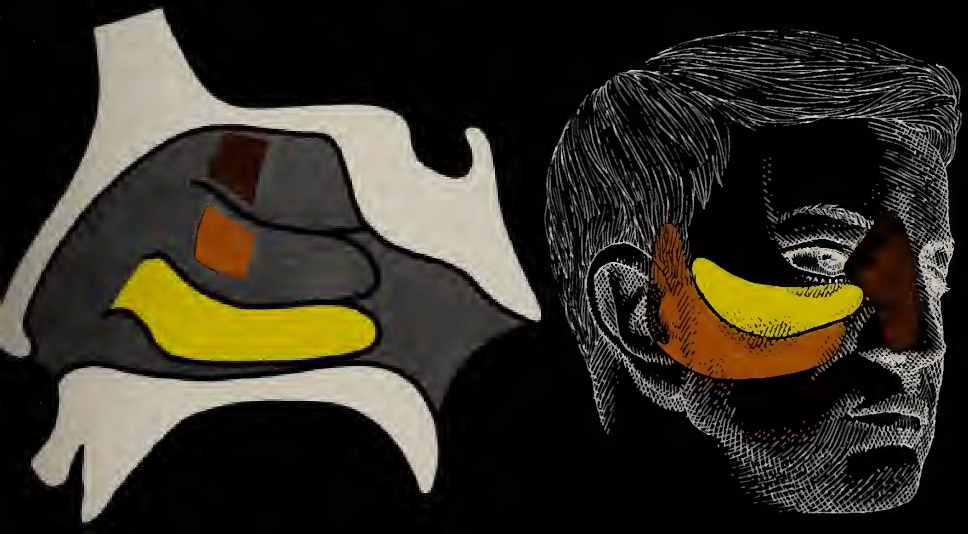


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

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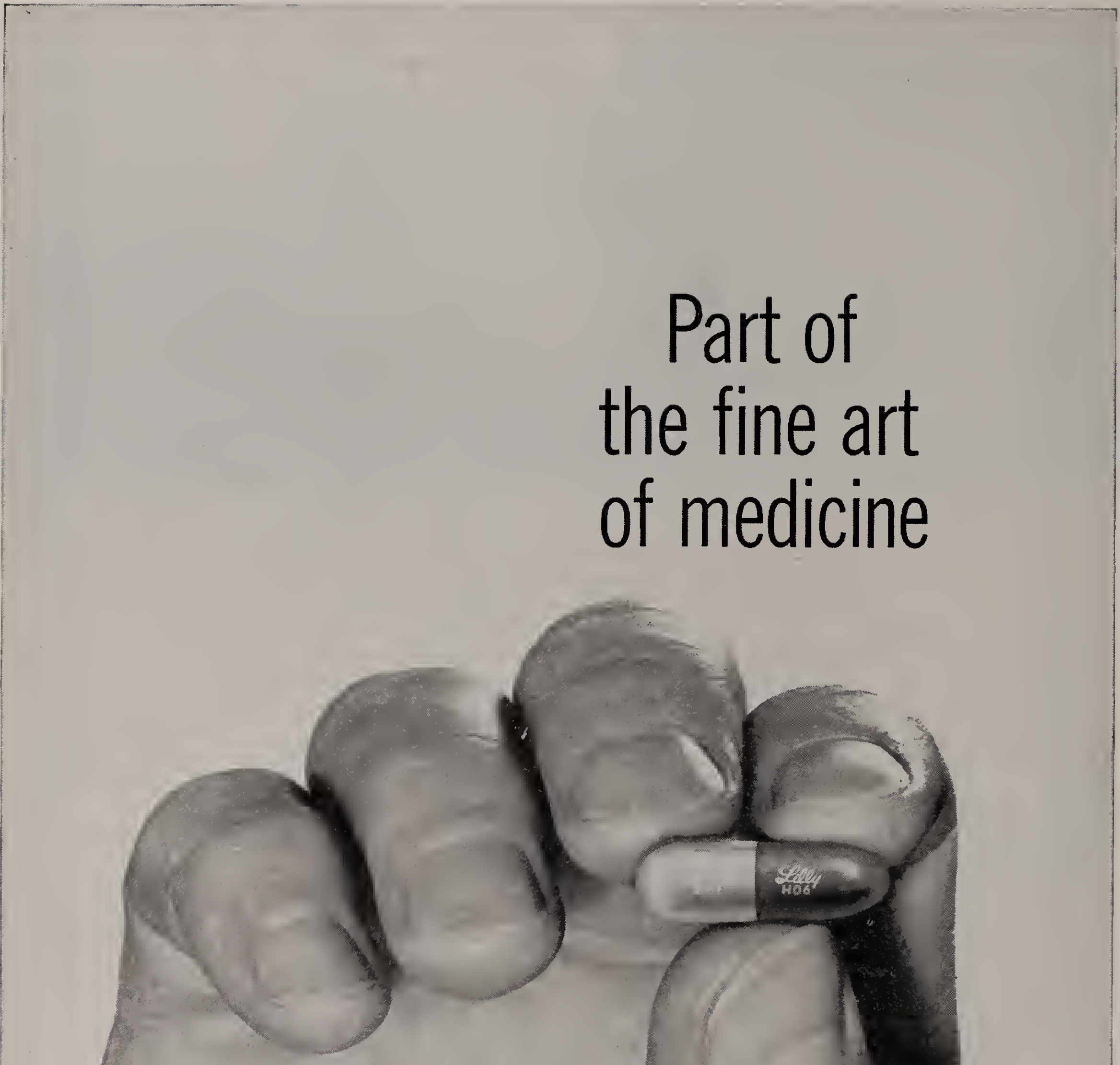
LIKED MICHIGAN PHOTO ON MAY COVER

The May issue of *Michigan Medicine* featured a photograph of Lake Michigan on the cover in a salute to the annual Michigan Week observance.

The cover drew a letter from William S. Smith, M.D., head of the section of orthopaedic surgery at the University Hospital, Ann Arbor. He wrote:

"The attractive cover on the May, 1968 issue of the Michigan State Medical Society Journal is indeed a pleasant departure from the conventional "throw-away" look.

"There are so many beautiful scenes of Michigan available, that the journal should consider a different one for every cover." ☐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Rupture of Pregnant Uterus

ABSTRACT: The article is a summary of a 10-year survey of ruptured uteri compared with an earlier article covering the previous sixteen years. The incidence in the latter is higher than in the former. Reasons for the increased incidence are noted. The fetal mortality in the present series is lower and maternal mortality was nil. A plea is made for awareness of diagnostic possibility and need for immediate action.

HELEN S. YAP CHAI, M.D.
FRED F. BIRKAM, M.D.
J. WALTON PICHETTE, M.D.
EDWARD A. DOUGHERTY, M.D.

Rupture of the pregnant uterus remains one of the most dangerous of the life-threatening accidents during the childbearing age.

It is an even greater menace to the unborn infant. According to Eastman and Hellman,[8] this condition produces more than half of the maternal deaths in uterine hemorrhage and is responsible for approximately 5% of maternal deaths. Garnet[10] states that 68% of the perinatal mortality in the United States associated with uterine hemorrhage is caused by rupture of the pregnant uterus. Any physician who practices obstetrics is exposed to this unanticipated and often unforeseen complication. The symptoms are frequently obscure, so that by the time the physician recognizes the condition, it is calamitous.

This challenging state, which can occur to any obstetrical patient at any time, demands the utmost in skills by the physician to decrease the extremely high maternal and fetal mortality rates.

This survey was prompted by the continuous hazard the ruptured pregnant uterus presents to the mother, fetus and the attending obstetrician. A 10-year review was documented and compared with the study of Birkam, Dougherty and Pichette,[3] published from this hospital, as well as studies of other authors.

There were 50,658 deliveries reported in the last decade in which there were 18 uterine ruptures. This incidence of 1:2814 is comparatively higher than the report of 1:4466 in the first 16 years of study of ruptured pregnant uterus in this hospital but compares favorably with the incidences reported by other writers (Table 1).

THERE WAS A LARGER number of traumatic ruptured uteri in our series; 20% higher than the previous study (Table 2). The etiology of these uterine ruptures in the present survey and the reasons for the increase were one or more of the following:

1. The increased use of cesarean section to solve obstetrical problems
2. Increased use of oxytocins
3. Poor obstetrical judgment.

Before discussing the frequency of this condition, we must define "ruptured uterus." According

TABLE 1 — INCIDENCE

AUTHOR	PERIOD	CASES	RATIO TO DELIVERY
Whitacre and Fang (China)	1922-1941	44	1:95
Paredes and Ismajovich (Paraguay)	1947-1957	27	1:515
McNides and McBurney	1923-1934	30	1:578
Delfs and Eastman	1920-1945	53	1:1010
Garnet	1958-1960	133 (114 hospital)	1:1034
Ferguson and Reid	1935-1955	84	1:1204
Bak and Heyden	1931-1953	52	1:1375
Voogd, Wood and Powell	1943-1955	12	1:1375
Pedowitz and Perell	1943-1954	87	1:1432
Ware, Jarrett and Reda	1932-1956	40	1:1508
Mathews, Raymond	1923-1959	111	1:1623
Waters, E.	1948-1960	50	1:2086
Ewing	1930-1956	37	1:2598
Salzmann	1950-1962	32	1:2665
Birkam, Dougherty and Pichette (MCMH)	1939-1955	17	1:4466
Yap Chai et al (MCMH)	1956-1965	18	1:2814

TABLE 2
ETIOLOGIC COMPARISON OF PRESENT AND PREVIOUS STUDIES

	1956-1965		1939-1955	
ETIOLOGY	Cases	Per Cent	Cases	Per Cent
— LCCS	2	11.1		
Cesarean		27.8	5	29.4
— Classical	3	16.7		
Previous surgery	2	11.1	1	5.9
Spontaneous	2	11.1	6	35.3
Traumatic	9	50.0	5	29.4
TOTAL	18	100.0	17	100.0

to Eastman,[8] it is a term to denote rupture only after the period of viability of the fetus, that is, 20 weeks or a fetus weighing 500 gm or more. The occult rupture or dehiscence is gradual in development and, as the name implies, is painless; whereas true ruptures are sudden in onset and almost always are associated with severe pain and shock. According to Kaltreider and Krone:[14] "Rupture is the separation of the entire uterine wall, with or without peritoneal involvement, associated with hemorrhage. Whereas dehiscence is not associated with hemorrhage and is often diagnosed at the time of elective surgery."

This study included only the cases with viable fetuses; our series ranges from 32-44 weeks with all occult ruptures.

Classification of the Causes of Ruptured Uterus

I. Rupture with previous scar
  A. C-Section
    1. Low transverse cervical C-Section — LCCS
    2. Classical C-Section
  B. Previous uterine surgery other than C-Section.

II. Rupture of Intact Uterus
  A. Spontaneous
    1. Associated abnormalities or diseases of the uterus
    2. Idiopathic
  B. Traumatic obstetrical procedures — forceps, breech extraction, version and extraction, pitocin or oxytocic induced labor, etc.

Case Review and Comments on Traumatic Ruptures

CASE 1. The patient was 24 years old, gravida III, para II, after 38 weeks of gestation in active labor with double footling presentation. Progress of labor was good for six hrs.; the cervix was 7-8 cm dilated when a prolapsed cord was noted. Breech extraction was performed under general ether anesthesia. A live girl weighing six pounds, 6 ounces was delivered. Examination of the uterus revealed a 3-4 cm laceration of the right lateral fornix and the right side of the cervix, extending about 7 cm into the fundus. A total abdominal hysterectomy was performed, and the patient received 1500 cc whole blood. Except for a low grade fever during the first four postoperative days, the postoperative course was uneventful. She was given Penicillin and Terramycin and was discharged on the 9th postoperative day.

Comment: There was proper management and diagnosis was established by immediate uterine exploration. The possibility of Duhrssen's incision might have been entertained.

CASE 2. The patient was 32 years old, gravida IX, para VII, and was seven months pregnant. Two weeks PTA, the patient had vaginal bleeding, weight gain, edema, elevated blood pressure and headache; fetal movements were absent. The patient went into spontaneous labor, after nine hours; a low forceps delivery was performed under spinal anesthesia. The head was delivered with ease, but when traction was made on the mascerated fetus, decapitation resulted. Evisceration was

The co-authors are all members of the staff of the Department of Obstetrics and Gynecology, Mt. Carmel Hospital, Detroit. Doctor Yap Chai is now in San Francisco.

attempted very carefully with a uterine dressing forceps, but failed. However, the trunk of the fetus was delivered by fundal pressure and a cervical laceration extending into the left broad ligament was felt on immediate exploration of the uterus. The patient had a subtotal abdominal hysterectomy. The blood pressure dropped to 60/30 during the procedure; otherwise, the postoperative course was uneventful. She received 1000 cc of whole blood.

Comment: Good postpartum management resulted since the diagnosis was established by immediate routine uterine exploration.

CASE 3. The patient was 30 years old, gravida VI, para V, at 39 weeks of gestation with a past history of orthopnea, ankle and pedal edema for four weeks. PTA. Her blood pressure was normal. Intravenous pitocin induction was given for three hours without commencement of labor. This was repeated 18 hours later, strong contractions started after 85 minutes. At this time a transverse presentation was noted with fast and irregular fetal heart tones. Pitocin was discontinued. Two hours later, contractions ceased and a slight drop in blood pressure to 90/64 was noted with severe abdominal tenderness and a slow fetal heartbeat. A Porro cesarean section was performed an hour later, and a six to seven inch rupture was found on the posterior aspect of the uterus. At laparotomy, a stillborn male fetus was found lying free in the abdominal cavity. The patient was in profound shock for 15-20 minutes. A cut-down was performed and Solu-Cortef and 2300 cc of whole blood were given intravenously. The postoperative course was uneventful.

Comment: The presentation of the fetus should have been accurately diagnosed prior to intravenous pitocin induction. Cesarean Section, if performed earlier, might have prevented the catastrophe to both the fetus and the mother.

CASE 4. The patient was 39 years old, gravida IV, para III, admitted at 41 weeks of gestation with false labor. Membranes ruptured spontaneously the following morning. A flat plate of the abdomen revealed a cephalic presentation. Quinine, gr X, was given; no contractions were noted. The following day, thick golden-brown amniotic fluid was seen, the patient was afebrile, intravenous pitocin induction was started. Contractions were every three minutes, lasting 35 seconds. After two hours, meconium stained fluid was noted. Vaginal examination showed questionable dilatation and undetermined presentation. Five and one-half hours after the intravenous pitocin was started, fetal heart tones ceased; the blood pressure was 90/50. Consultation was obtained and a subtotal hysterectomy with bilateral salpingo-oophorectomy was performed for rupture of the right posterolateral half of the uterus and cervix extending into the broad ligament, infundibulopelvic ligament and posterior parietal peritoneum. A dead male infant weighing seven pounds, nine ounces was found free in the abdominal cavity. The patient was in shock and received 2500 cc of whole blood.

Comment: If attention had been focused on the meconium stained fluid in a cephalic presentation with a near floating head plus irregular fetal heart tones, consultation would have been sought immediately and pitocin omitted.

CASE 5. The patient was 31 years old, gravida VI, para IV, abortus I, admitted at 39 weeks of gestation after spontaneous rupture of the membranes 1½ hours earlier. Quinine, gr X, was given and repeated four hours later. Eleven hours later she delivered, spontaneously a live boy weighing eight pounds, ten ounces. Immediately, the mother went into shock. Prompt exploration of the uterus revealed a long, deep laceration at the left lateral cervix extending into the lower uterine segment and uterus. Subtotal abdominal hysterectomy with right salpingo-oophorectomy was performed because of blood extravasated into the right infundibulopelvic ligament. She received 3000 cc of whole blood. The postoperative course was uneventful.

Comment: Diagnosis was established immediately upon routine uterine exploration.

CASE 6. The patient was 36 years old, gravida VI, para V, admitted at term in labor. Four and a half hours later, Pinard's maneuver was performed and a male infant weighing eight pounds, 13 ounces was delivered in good condition by breech extraction. Uterine exploration was performed with a negative result. About two hours later, a slight drop in blood pressure to 80/60 was noted, the pulse was 80 and regular; 1000 cc of 5% glucose in water was started. Four hours later, a mass the size of a football was palpated at the right adenxa. Supracervical hysterectomy with bilateral salpingo-oophorectomy was performed. A tear 5 cm long in the lower segment, extending into the right broad ligament with hematoma formation laterally and posteriorly to the right kidney was found. There was free blood in the peritoneum. The patient received 3500 cc of whole blood and 25 gm Mannitol and terramycin. She recovered uneventfully.

Comment: Importance of a thorough and careful uterine exploration is emphasized.

CASE 7. The patient was 33 years old, gravida VII, para VI, at 40 weeks in gestation with questionable labor and a transverse presentation, with the head to the right and the back inferior. External version was attempted and failed, but there was success on the second attempt with good fetal heart tones. A low forceps delivery under spinal anesthesia was performed after eight hours, followed by discovery of uterine rupture at the midportion of the lower uterine segment, extending into the fundus uteri approximately five inches. The tear curved somewhat to the left side and extended to within five cm of the tubouterine junction. Subtotal abdominal hysterectomy was performed with a right salpingo-oophorectomy; 1000 cc of whole blood was given. The postoperative course was uneventful.

Comment: Diagnosis again was rendered on routine uterine exploration. The advisability of external version may be controversial.

CASE 8. The patient was 39 years old, gravida IX, para VII, abortus I, after 40 weeks gestation and active labor for 11 hours. Breech extraction was executed with extraction of left nuchal arm under ether anesthesia. On routine uterine exploration, a posterior cervical laceration was found which extended into the right posterolateral side of the uterus with a hematoma in the right broad ligament. A supracervical hysterectomy with right salpingo-oophorectomy was performed. She was given 2500 cc of whole blood plus 4 cc of Levophed and calcium gluconate intravenously. The patient was in shock throughout the procedure. Her condition was fairly satisfactory until two hours later when moderate vaginal bleeding was noted and an exploration was made abdominally. A laceration 2 cm long was found at the right lateral aspect of the vagina and was repaired. The postoperative course was uneventful except for pulmonary congestion on the first day. She was discharged the 8th postoperative day with a hemoglobin of 9.9 gm.

Comment: Again, the diagnosis was obtained by immediate postpartum exploration of the uterus.

CASE 9. The patient was 44 years old, gravida XVII, para XV, abortus I, admitted after 40 weeks of gestation with contractions every three minutes and moderate vaginal bleeding; fetal heart tones were absent. A cytogram revealed no evidence of placenta praevia; ROT was station -3. Desultory labor for 14 hours was unimproved with intravenous pitócin. The uterus became tense; therefore, cesarean section was performed for primary uterine inertia and questionable marginal sinus rupture or abruptio placenta. A tear was found involving the whole thickness of the anterior myometrium, extending from the fundus to the bladder flap and hematomas were located in both adnexae. A stillborn male weighing eight pounds, fourteen ounces with intact membranes and pea soup thick amniotic fluid was seen. A subtotal hysterectomy with bilateral salpingo-oophorectomy was performed without blood transfusion. No complications were noted postoperatively.

Comment: Pitocin intravenously is contraindicated for a grand multipara and/or a floating head.

In the non-traumatic causes, the dictum "once a section always a section" still holds true, and this principle is followed by this department. An important example: a woman 25 years old gravida IV, para III, who had a cesarean section at her second delivery, for bleeding. She was allowed vaginal delivery with the third pregnancy. On the fourth admission, she was one week overdue and spontaneous delivery of a male infant weighing nine pounds, 13 ounces occurred in six hours. Immediate postpartum hemorrhage occurred. Exploration revealed rupture through the previous cesarean section scar. Subtotal hysterectomy was followed by uneventful recovery. She received 2500 cc whole blood for mild shock.

Maternal and Fetal Mortality Rates

In spite of the moderately higher incidence of uterine rupture in our series, it is gratifying to find a lower fetal mortality rate and the absence of maternal mortality in the present survey.

O'Driscoll and Quinn[14] pointed out that tear of a previous cesarean section scar may rank high in the list of causes of uterine rupture, but the maternal mortality rate is usually low (Table 3). In contrast, the maternal mortality rate in traumatic and spontaneous ruptures by comparison is high.

Factors Which Decreased Maternal and Fetal Mortality Rates

1. Early diagnosis — by immediate uterine exploration of all postpartum cases and especially those with previous uterine surgery, traumatic deliveries, pitocin induction, etc.
2. Early surgical intervention.
3. Adequate fluid, blood and drugs to combat shock.
4. Awareness of the dangers involved in traumatic obstetrical problems.
5. Use of antibiotics as indicated.

   Diagnoses were rendered in both traumatic and non-traumatic cases:

a. In ten patients on routine uterine exploration with or without signs and symptoms of vaginal bleeding and/or shock. Of these, five presented with vaginal bleeding; seven were in shock.

b. One was diagnosed preoperatively as abruptio placenta, another as primary uterine inertia, and the third as impending uterine rupture.

c. Five were diagnosed because of palpable superficial parts and absence of fetal heart tones.

d. One was diagnosed at surgery.

These cases point out the importance of routine uterine exploration of all postpartum cases, especially following complicated deliveries, with or without external bleeding. The only exception, of course, is the case of gross intrauterine infections.

There were 7 fetal deaths and 11 live births among the 18 cases, which constitutes a 38.8% fetal mortality. However, one of the newborns died after 14 minutes in spite of resuscitation. Still, this figure is considerably lower than the average 68% fetal mortality rate in the United States. It is to be noted that the early diagnoses of ruptured uterus, good surgical technique and early institution of shock therapy, resulted in no maternal mortality and a considerable lowering of the fetal mortality rate.

Treatment consists of total abdominal hysterectomy with or without salpingo-oophorectomy in seven patients, subtotal hysterectomy in nine patients and two cesarean sections with repair of the ruptured area in two patients.

TABLE 3
MATERNAL MORTALITY IN UTERINE RUPTURES

		Post-Cesarean	Mortality		Non-Cesarean	Mortality	
AUTHORS	PERIOD	CASES	Number	Per Cent	CASES	Number	Per Cent
Delfs and Eastman[6]	1900-1944	10	2	20.0	43	23	53.5
Brierton[4]	1932-1946	46	1	3.8	31	18	58.1
Donnelly[7]	1931-1948	13	0	0.0	26	11	42.3
Beacham and Beacham[2]	1913-1950	23	6	26.1	73	40	54.8
Garnet[12]	1929-1952	6	1	16.7	15	11	73.3
Bak and Heyden[1]	1931-1953	13	0	0.0	37	8	21.6
Pedowitz and Perell[15]	1933-1954	34	1	2.9	41	9	22.0
Burkons[5]	1949-1954	35	1	2.9	30	6	22.0
Ferguson and Reid[9]	1935-1955	18	1	5.6	24	4	16.7
Ware, Jarrett and Reda[17]	1932-1956	16	0	0.0	55	10	18.2
Posner, Santos and Posner[16]	1949-1957	12	0	0.0	14	1	7.1
*Birkam, Dougherty and Pichette[3]	1939-1955	5	0	0.0	12	3	25.0
*Present Study	1956-1965	5	0	0.0	13	0	0.0
TOTAL (average per cent)		216	13	6.01	414	144	34.78

Summary

1. Eighteen cases of ruptured uterus occurring between 1956-1965 have been reviewed.

2. A comparison was made of the incidence of 1:2814 with that of other authors and our previous study.

3. Traumatic ruptures rank highest in the list, constituting 50% of all cases.

4. No maternal mortality was encountered.

5. Fetal mortality rate was 38.8%, lower than the average.

6. Treatment of ruptured uterus is presented.

7. A serious plea for routine exploration of the postpartum uterus is emphasized.

8. Traumatic ruptures can be avoided, in part, by more zeal and watchfulness on the part of the physician.

9. Early diagnosis decreases maternal mortality, morbidity and fetal mortality.

Editorial Note:

Obstetrics usually represents one specialty in which the end result usually leads to happiness on the part of all parties involved. Ruptured uterus is a catastrophe that is life-threatening to both mother and child and causes dismay in an otherwise happy situation. As the authors point out, the obstetrician should keep this possibility in mind and be ready for immediate intervention.

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Atypical Mycobacteria In the Detroit Area

ABSTRACT: The classification of the atypical mycobacteria is reviewed. Clinical disease in the Detroit area is most frequently due to Type III. Type II (Scotochromogens), almost always a non-pathogen, is the most common organism isolated.

BY OSCAR BIGMAN, M.D.
MORRIS F. WHITE
BOTH OF DETROIT

Although the atypical mycobacteria have been known for many years and the main identifying features classified by Runyon,[1] subclassification is still in process.[2, 3] Table I indicates the current but tentative classification. Organisms occasionally fall between the categories and are difficult to place specifically.

Organisms in the left hand column are considered pathogenic.

It was thought worthwhile to review the experience within the Detroit area to guide clinicians as to which organisms may be found in the vicinity and as to which ones may be difficult to treat.

A previous paper by R. A. Green[2] presents the only source of information previously available as to cases found in the State of Michigan. All the organisms were collected either in the Out-Patient Clinic or on the In-Patient Service at Herman Kiefer Hospital between Jan. 1 and Dec. 31, 1965. Out-patient records were not reviewed in detail since many of the sputa were submitted by patients under the care of private physicians and the clinical information available was inadequate.

A total of 479 out-patient sputa were positive for atypical organisms. There were 459 isolations of Group II, one of Group III, nineteen of Group IV. M. Kansasii (Group I) was never found.

Table II indicates the relative frequency with which M. tuberculosis and atypical mycobacteria were found. It will be noted that in the outpatient services atypicals were found more frequently than "typicals." Of course, most of these were Group II, non-pathogens.

Table III indicates the nature of the disease in patients whose sputa contained Type II-scotochromogens.

TABLE I — CLASSIFICATION

Runyon Group I	Photochromogens	
M. Kansasii		
Runyon Group II	Scotochromogens	
M. Scrotuloceum		tap water (aquae)
Runyon Group III	Nonchromogens	
Battey bacillus		M. Terrae
M. Avium		M. Gastri
M. Xenopei		
Runyon Group IV	Rapid growers	
		M. Fortuitum
		M. Phlei

TABLE II
SUMMARY OF ALL SPUTA SUBMITTED TO THE LABORATORY IN 1965

	Inpatient		Outpatient	
Negative for AFB	11,906	84.6%	11,958	91.1%
Positive for M. tuberculosis	2,007	14.3%	186	1.4%
Positive for atypical mycobacteria	102	0.7%	479	3.6%
Contaminated	51	0.4%	510	3.9%

Both authors are associated with the Herman Kiefer Hospital, Detroit.

TABLE III — IN-PATIENTS

Group II Scotochromogens only isolated		
benign non-progressive disease	isolated once 12 patients	more than once 2 patients
pneumonia clinically	isolated once 3 patients	more than once 1 patient
patient expired	isolated once 6 patients	more than once 1 patient
Group II and M. tuberculosis isolated	isolated once 16 patients	more than once 4 patients

Single isolates of Group II were obtained from three patients with bronchiectasis, one with pneumoconiosis, one with sarcoidosis.

The out-patient experience shows that there are many Group II Scotochromogens isolated in the Detroit area. Whether in the clinic with an insignificant lesion, or whether admitted with a more suspicious lesion, these Scotochromogens (aquae) are benign. Sometimes they appear coincidentally to a mycobacterium tuberculosis infection, in which situation they do not seem to alter the prognosis. They are probably contaminants derived from soil and water where they are commonly found. Occasionally cavitary disease is found. It is difficult at this time to know whether this represents a different strain (scrofula) or host resistance deficiencies.

The isolation of Group IV, rapid growers, M. Fortuitum or M. Phlei also seems clinically benign in our limited expreience.

On the other hand, the isolation of Group III, Battey bacillus, seems to carry a grave prognosis, our two patients showing inexorable progression to death.

These observations agree with the general consensus that Groups I and III are pathogenic and that the exact role of Groups II and IV are yet to be established. Further subdivision of Groups II and IV into laboratory distinct strains are needed.

CASE HISTORIES

1. (46054)

R. K., A 71-YEAR-OLD WOMAN was admitted on July 30, 1964 and expired on July 4, 1965. She had noted progressive dyspnea for 3 or 4 years, productive cough for 2 months, hemoptysis for 1 week. She had lost 20 lbs. in the previous year. She complained of night sweats for the previous 2 months.

TABLE IV

Group III	Battey	
	R.K.	Patient expired. The organism was isolated on eleven occasions.
	W.A.	Patient expired. The organism was isolated on ten occasions.
Group IV	M. Fortuitum	
	M.R.	Cystic disease of lung. Organism isolated once.
	F.H.	Recurrent migrating pneumonia. Organism isloated once.
	D.C.	Right middle lobe pneumonia. Organism isolated once.
	J.R.	"Classic" tuberculosis. M. Hominis isolated on five occasions. M. Fortuitum on one occasion.
	H.B.	Pneumonia in patient with carcinoma of the lung. M. Fortuitum isolated on one occasion.

In one patient, S.D., who clinically had silicotuberculosis, the organisms were apparently variable in cultural characteristics, being classified as I, twice; II, twice; and IV, three times.

Past History: Glaucoma for eleven years, treated with iridectomy, on the right. A daughter had had tuberculosis 15 years ago.

Physical Examination: Iridectomy, right eye. Lungs — moist rales at right base, soft apical systolic murmur. 1+ pedal edema.

Sputum cultures were always positive for mycobacteria Type III. X-rays showed slow progression. The patient became gradually more dyspneic and anemic. She was treated with isoniazid, streptomycin, P-amino-salicylic acid. Erythromycin added later, failed to alter the course of the disease.

2. (45356)

W. A., A 50-YEAR-OLD MAN was admitted on December 27, 1963 and expired on July 15, 1965. He had had bronchial asthma, non-seasonal, since the age of 18. Ten months prior to admission, he had developed a productive cough and weakness. He denied weight loss, fever and night sweats.

Past History: Heavy smoker and drinker. Occupation — janitor.

Physical Examination: Not remarkable except for absence of teeth, an increased A-P diameter of the chest and bronchial breath sounds in the left infraclavicular region.

Hospital Course: The patient was treated with streptomycin, isoniazid, P-amino-salicylic acid from 12/30/63 to 1/30/65. X-rays improved but the sputum remained positive for atypical mycobacteria. There was difficulty in classifying the organisms. On 4 occasions they were considered to be Group III and on 6 occasions, Group IV. In January, 1965, the combination of ethionamide, cycloserine and isoniazid were started. The X-rays began to show deterioration in the Spring of 1965. The patient expired quietly on July 15, 1965.

3. (43962)

S. D., A 75-YEAR-OLD MAN was admitted on October 12, 1965 for hemoptysis on two occasions. He had had a "cold" with cough and soreness of the left chest for about three weeks. Weight loss, fever and sweating were denied. Past history revealed that the patient had been a foundry worker for 27 years. He smoked 10 cigars a day. The main finding on physical examination was the presence of cavernous breath sounds in the left apex. On isoniazid, P-amino-salicylic acid, streptomycin and pyrizinamides, the cavity became smaller. The patient was discharged as "open negative" on May 27, 1965. Sputum was positive for atypical tubercle bacilli on seven occasions. The organisms were varibly identified as being of Group I, II and IV.

He was readmitted on March 12, 1967 for minor X-ray progression of his pulmonary disease. The intermediate PPD skin test produced an 11 mm. area of induration. Atypical mycobacteria were again isolated. The patient expired on May 24, 1967, following a transurethral resection, apparently of uremia.

ACKNOWLEDGEMENT

The assistance of Paul Chapman, M.D. and Isidore Selzer, M.D. in making available the charts and laboratory data herein reported, is gratefully acknowledged.

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Editorial Comment:

In the past many people were hospitalized in tuberculosis sanitoria for nontuberculosis lesions. Seldom today do we see hospitalization for tuberculosis with such conditions as sarcoid and histoplasmosis. However, the atypical mycobacteria can still be a fooler. It is also interesting to note that not all atypical mycobacteria are innocuous. JWM.

The Programmatic Aspects of The Michigan Regional Medical Program

BY ALBERT E. HEUSTIS, M.D., M.P.H.
EAST LANSING

The establishment of a special President's Commission and passage of Congressional legislation regarding cancer, heart disease and stroke will give great impetus to the efforts of sharing the knowledge of treatment of these diseases.

The Commission has submitted a report which includes the following two quotations:

> FIRST — "A significant number of Americans with these diseases (cancer, heart disease and stroke) die or are disabled because the benefits of present knowledge, in the medical sciences, are not uniformly available throughout the country."

> SECOND — "A creative partnersip must be forged among the Nation's medical scientists, practicing physicians, and all of the Nation's other health resources, so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions."

Then, in the opening section of Public Law 89-239 itself, we find the purposes of the legislation defined as follows:

> "Sec. 900. The Purposes of this title are —
> (a) "Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases;
>
> (b) "To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and
>
> (c) "By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

On the basis of these statements, what then is the involvement of the local physician in the Michigan Regional Medical Program?

INVOLVEMENT OF LOCAL PHYSICIANS

Everywhere along the line and at every level of policy and program development, the local physicians of the state have been well represented:

1. At the level of absolute control over what is submitted to Washington for funding, there are five local physicians on the Regional Advisory Group.
2. At the level of the Board of Directors who govern the affairs of the Corporation, there are two local physicians.
3. In the Professional Advisory Councils:
   Heart Disease has seven.
   Cancer has nine.
   Stroke has five.
4. On the Task Forces:
   Incidence and Prevalence has one.
   Continuing Education has three.
   Compatability of Educational Media has one.
   Methods and Evaluation has two.
5. Less active perhaps so far but with great potential for the future are the local physician representatives on the local advisory committees of our great universities.
6. We are asking that all those involved in the planning of projects be clearly identified in order to emphasize the need for the potential receivers — the learners and users of the in-

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formation — to be involved in the development of those things designed to serve their local needs.

7. In our embryo State Plan, approved as a working document upon which to request funds, we see our medical centers working with local physicians in larger hospitals and we see those local physicians in turn — in ways acceptable to both — involving local physicians in smaller or community hospitals along the line of usual patient referral.
8. This Planning Conference represents the second time that officials and staff of the Michigan Regional Medical Program have been invited to present material to an official Michigan State Medical Society gathering and in addition the staff has met individually with a number of MSMS Committees and participated in an official MSMS called meeting to which the chairmen of all Medical Society Committees believed relevant were invited.

CURRENT STATUS

The Michigan Association for Regional Medical Programs has operated under a planning grant since June 1, 1967 — a relatively short period of time. While the University of Michigan initiated activity in July, other participants and the Central Office itself did not get staffed until the last quarter of 1967.

During this time the Central Office has:

1. Become organized and located.
2. Developed three Professional Advisory Councils, four Task Forces and two Ad Hoc Committees and provided staff work therefor.
3. Assisted those with an interest in developing programs.
4. Reviewed and made recommendations on projects submitted by the University of Michigan, the Michigan Heart Association, Michigan State University, Wayne State University, Michigan Department of Public Health and the Zieger/Botsford Hospitals.
5. Cooperated with the State of Michigan in the early planning phases of the development of the State Office of Comprehensive Health Planning.
6. Developed working liaison with the Minnesota and Wisconsin Regions regarding those problems of mutual interest.

The Michigan Department of Public Health has made a start on planning and developmental work and is developing a system of coordinated data collection and anaylsis to insure the comparability of all data collected in the region.

The University of Michigan has been doing central planning and coordination, trying to plan a Cancer Chemotherapy project, developing a program for Post Graduate Education of Nurses, establishing a Drug Therapy Information and Drug Therapy Analysis Reporting System and has started to plan for the training of non-professional personnel.

Michigan State University has established a Planning and Facilitating Office, and Wayne State University is getting started in the planning area, having just engaged their first personnel as of February of this year.

THE 1968-69 FEDERAL FUND REQUEST

Future activities include the projects which were approved by the Corporation's Regional Advisory

THE AUTHOR

Doctor Heustis, former director of the Michigan Department of Public Health, is the director of the Michigan Association for Regional Medical Programs (MARMP).

Group on February 2, 1968, and which have been sent to Washington for consideration of Federal funding.

Briefly summarized this project request consists of:

1. A central planning and administrative staff.
2. Planning staffs for the University of Michigan, Michigan State University, Wayne State University and the Michigan Department of Public Health.
3. The planning and initial development of an on-going population survey which will assess the state of health, provide up-to-date rates for small areas for morbidity and mortality, pinpoint populations and areas of concern and provide information on patterns of utilization of health services.
4. The development of an approach to automated screening.
5. A survey which will assess physicians' attitudes with respect to continuing education.
6. The development of a physician education program primarily for osteopathic physicians.
7. Community training programs for physicians and nurses in coronary care concepts.
8. Continued education for nurses, both at the universities and in the field.
9. Development of a system to provide drug information to physicians.
10. The study of ways in which to utilize and train non-professional personnel.
11. The evaluation of medical care services from the viewpoint of the patient and the planning for indicated improvements.
12. The planning of a continuing education program for dentists to improve services to patients with cancer, heart disease and stroke.
13. The planning for a community program for the management of stroke.
14. Assessment of the needs of low income populations.
15. Initiating a training program concerned with the diagnosis of hypertension.

CONCEPTS AND PRINCIPLES

Concurrently with the planning and development proceeding in some of our institutions, the Central Office has been working with the Professional Advisory Councils and Task Forces to develop general concepts and principles to guide staff action in the stimulation, development and review of project applications. These are presented here as an integral part of the emerging plan for Michigan's Regional Medical Program.

1. The goal of the Michigan Regional Medical Program is to advance the accessibility and the quality of health services available to individual patients throughout the region through regional arrangements designed to stimulate new patterns of cooperative action among physicians, hospitals, university medical centers, public health and voluntary health agencies.
2. In addition to universities, a wide range of health related community, district and statewide agencies will be encouraged to develop projects with the provision that applicants must have the ability to take full fiscal and operational responsibility for projects developed and have recognized competence in the area of concern or a demonstrable potential.
3. Projects to be considered for funding cannot be isolated activities but must relate to the overall development of Michigan's Regional Program.
4. In general, projects must provide for some immediate relevance for the improvement of patient care or for better utilization of manpower.
5. Projects must have as an objective the making of a practical contribution to the effective diffusion of knowledge throughout the region and to the lessening of the gap between knowledge and practice as it affects the care of individual patients. They should have some immediate impact in communities and hospitals not now affiliated with the medical schools and should be programmed to be geographically inclusive with an indication of the phasing anticipated for total coverage.
6. Projects must identify specific working interrelationships and cooperative arrangements that have been developed or anticipated with other agencies.

7. Patient care demonstration projects must either be replicable elsewhere in the region or have a clearly defined impact throughout the region on physician capability through training.

8. Projects will be concerned with those aspects of the subject diseases and of the health care system in which input of funds will result in maximum benefit in improving the care of individual patients.

9. Funding of projects relating to the care of low income urban groups will be encouraged.

PROCEDURES

To implement these principles, a consistent approach has been defined which, incorporated in the majority of projects funded, will organize what might otherwise be disconnected activities into a regional program.

1. Inasmuch as group consensus can be more effective in changing behavior than individual learning, the primary target for a decentralized approach to improved care of patients is the hospital staff.

2. Working with hospital staffs will be undertaken in conformity with a logistic regionalization concept whereby smaller or community hospitals relate along patient referral lines to larger district (sub-regional) hospitals or hospital centers and these in turn relate to a university medical center.

   The role of the medical center in a decentralized approach should be to work through larger or district (sub-regional) hospitals or hospital centers and their staffs, which in turn accept the responsibility for the involvement within their normal area of patient referral, of the smaller community hospitals and their staffs.

   Thus, a well organized district hospital (with a specialist staff and director of medical education) functioning as a training and service center will serve as a communication link between university and community hospitals, lessening the gap between knowledge in university medical centers and practice in community hospitals.

3. In all programs designed to improve patient care in order to have maximum impact, the effort should ideally be multi-disciplinary, providing for interrelated training of physicians, nurses and other personnel.

4. All applications must include specific assurances that continuing education offerings will be available to all medical and osteopathic physicians in the area regardless of hospital affiliation.

5. All projects will contain clearly stated objectives capable of realistic evaluation.

THE EMBRYO STATE PLAN

Within these principles and procedures, our embryo State Plan is as follows:

HEART DISEASE. Each district hospital or district hospital center will be encouraged and otherwise assisted in reviewing current practices regarding the handling of patients with acute coronary disease and wherever indicated will be assisted in developing and implementing an adequate concept of cardio-vascular care which will fit into its particular circumstances, with said district hospital or district hospital center and the medical staff thereof (with needed assistance from a medical school) accepting the responsibility of working with the smaller or community hospitals within its referral area, so that available new knowledge may be received in a fashion that will facilitate the improvement of patient care at the community level.

At least one training program in acute coronary care will be made available to each district hospital or district hospital center with the involvement of one or more community hospitals in each district area.

Comprehensive programs for the medical management of persons with hypertensive disease will be developed in the same way, with the district hospital or district hospital center serving as a resource for those medical specialties, diagnostic studies and treatment facilities not available at the community hospital.

STROKE. Comprehensive program for the medical management of stroke patients will be developed in the same manner as for heart disease and will include the pre-stroke phase on through the continuing care of post-stroke patients in long term care facilities, in their own homes or in nursing homes.

CANCER. Each district hospital or district hospital center will be encouraged and otherwise assisted in reviewing current practices in the primary diagnosis and treatment of patients with cancer, and wherever indicated will be assisted in developing an adequate program for the primary diagnosis and treatment of cancer patients.

With the help of, and the involvement of the medical staff of its district hospital or district hospital center, each community hospital will assess its own potential for the primary treatment of cancer taking into consideration the availability of specialist personnel and adequate diagnostic and therapeutic equipment, including nuclear medical components, and will determine a proper scope of services for itself and a proper relationship for patient referral between it and the district hospital or district hospital center.

With the assistance of a university medical school, each district hospital or district hospital center will develop competence in the curative and/or palliative aspects of cancer chemotherapy, and, through mutually worked out and acceptable mechanisms, share such knowledge and make its facilities and competencies available to the community hospitals in its area.

APPLICATION INFORMATION

Any group wishing to make an application to participate in Regional Medical Program funding by establishing a **cooperative working arrangement** may get started by just writing the staff a relatively brief letter outlining what they have in mind and with whom they plan to work cooperatively and sharing whatever information they have on timing and on costs. This will serve as a basis for initial staff discussions on a sub-regional or district hospital basis and after this, if feasible, a formal application may be prepared. We are at the present time seeking eight energetic men or women in the 10,000-14,000 dollar class to work in local areas to assist in project development.

THE VOLUNTARY NATURE OF THE PROGRAM

As a concluding note, everyone should be reminded that this is a **voluntary program** and that all goals and concepts herein discussed are most certainly subject to such modification or change as may be necessary to enable physicians to receive such help as they would like to receive and to receive this help in an acceptable and useable fashion. ☐

Office Management Seminar In Detroit, September 26

One of the features on the program of the MSMS Annual Session will be a Seminar on Office Management, on the afternoon on September 26, designed especially for newly-practicing physicians, residents, interns, senior medical students, and the interested wives.

The MSMS Liaison Committee with Residents, Interns, and Senior Medical Students, under the chairmanship of Norman Henderson, M.D., East Lansing, has developed a program to have maximum value in helping young Michigan physicians set up their practices according to flexible and efficient management principles.

Merck, Sharp, and Dohme pharmaceutical company is providing financial support for the seminar and will provide a special Office Management Handbook for participants in the seminar.

Michigan professionals who work closely with physicians in the business side of their practice will share their experience and counsel with the young doctors. Charles V. Brown, of Detroit, will speak on "Personnel Selection and Training;" C. Allen Willmar, Saginaw, will discuss "Setting Up Practice;" John K. Hoffman, Grand Rapids, will discuss solo practice and the various forms of partnership arrangements; R. Timothy Hogan, Ann Arbor, will speak on "What Shall I do With the Money I Earn;" and Carl King, Jr., Saginaw, on "Billing and Collection Systems." The first four speakers mentioned are all members of Black & Skaggs Associates, a Michigan firm which has been involved in professional management for physicians and dentists since 1932. Mr. King handles a billing and collection system for physicians in the Saginaw area.

Helps Dedicate School Named for Grandfather

Main speaker at dedication exercises of the Dr. Samuel A. Mudd Elementary School in Waldorf, Maryland, was Richard D. Mudd, M.D., of Saginaw, the grandson and only living physician descendant of Doctor Samuel Mudd, who lived from 1833-1883.

Doctor Richard Mudd, retired after 36 years as medical director of various divisions of General Motors, keeps busy by helping out several physicians and acting as a consultant.

WSU HONORS HALE

Ten Wayne State University professors with a combined total of nearly 300 years at the University were honored at the Service Recognition Tea June 16. The group included Esther H. Dale, M.D., Detroit, professor of pathology, 38 years.

State to Continue Study of Medical Education, Needs

The study of Michigan's educational programs for medical and allied health personnel will be continued by the Michigan State Board of Education, thanks to a recent grant of $98,680 from the W. K. Kellogg Foundation of Battle Creek.

In the past two years the Committee has been inventorying existing health manpower resources and educational capacities of the state to alleviate existing deficiencies and to plan for future needs.

Edwin L. Novak, of Flint, State Board of Education President, said that the grant will be used to subsidize salaries of the Committee's staff for two years, providing for a project director and assistant, two researchers and staff travel as well as office equipment and supplies.

In addition to working on a state plan for adequate health care education facilities, the 17-member Committee will help develop demonstration projects in allied health education such as medical technology and para-professional fields.

Thoughts of MD-of-the-Year:

In 1965, MSMS cooperated with the Michigan Tuberculosis and Respiratory Diseases Association to present Irvine H. Page, M.D., who was selected by the AMA in San Francisco as the "Outstanding Physician of the Year." Doctor Page, formerly with the Cleveland Clinic and now retired and living in Indianapolis, presented many provocative points in his 1965 Yates Address at MSU. His comments included these:

"Uncertainty lies now in what we are going to do for people, why we want them here and how long we want them alive.

"The last 40 years of science have done more to change our lives than all the rest of recorded time.

"More obesity begins at the family dinner table with children than ever originates later on.

"We are hereditarily conditioned organisms trying throughout our lifetimes to adjust to a hostile environment."

FIRST DO ADMITTED

Recently osteopathic physicians were offered full staff privileges at Sparrow, St. Lawrence and Ingham Medical hospitals in Lansing, and Ann Agustsson was the first osteopath admitted to the staff at Ingham Medical. She is a graduate of MSU and the Chicago osteopathic school.

MSMS RELEASES PUSH CAREERS IN HEALTH FIELD

High school graduates have been urged by MSMS news releases to consider health careers. In addition to describing the needs, MSMS President Bradley Harris, M.D., outlined a variety of health careers.

The news feature was headlined many ways. Among them:

Stockbridge Town Crier & Brief Sun: "High School Students Urged to Consider Medical Career"

Cedar Springs Clipper: "Many Opportunities in Field of Health"

Pioneer Press, Bear Lake, Manistee County: "More Medical Personnel Needed Everywhere"

Detroit East Side Express: "Seniors Urged to Consider Careers in Medical Field"

Farmington Enterprise & Observer: "Skilled Help Short In Health, Medicine"

Dimondale News: "Students Urged to Consider Medical Career"

Michigan Chronicle, Detroit: "Cite Unlimited Health Careers"

Livonia Observer: "Skilled Help Short in Health, Medicine"

Ingham County News: "Students Urged to Consider Medical Careers"

Montague Observer: "High School Students Urged to Take Medical Courses"

KAHN LEAVES U-M, JOINS HOWARD

Reuben L. Kahn, M.D., noted professor-emeritus of serology in the University of Michigan's Medical School, recently took over new duties as professor of microbiology at Howard University in Washington, D.C.

Previous to his new appointment, Doctor Kahn had been doing research at the U of M Kresge Medical Research Building and acting as research consultant in dermatology on the University staff.

Doctor Kahn achieved world renown when he developed a serological test for syphillis in 1923.

Doctor Kahn, who had been at the University of Michigan since 1928, was named to the Michigan Health Hall of Fame in 1965.

USPHS HELPS MSU

The federal government has granted $2,534,035 to Michigan State University to support construction of a $10 million Life Sciences Building for medical teaching.

The Michigan Legislature recently authorized $1 million for initiating construction with the understanding that an additional $3 million will be needed over the following two years. The Kellogg Foundation has granted $625,000 to support the construction.

Work is expected to begin this fall.

MSMS HELPS AREA REHAB CONFERENCE

About 100 physicians and interested lay people participated recently in an area Conference on Rehabilitation and Long Term Care of Elderly Patients at Saginaw County Hospital.

Sponsored by the MSMS Committee on Aging, Bay, Midland, and Saginaw county medical societies, and the Saginaw Veterans Administration Hospital, the conference dealt with both the professional and administrative problems related to rehabilitation and long term care of the elderly.

Chairman of the MSMS Committee on Aging, A. Hazen Price, M.D., Detroit, presided at the dinner which closed the conference.

New Rates Set For Nursing Homes

New rates for State payments to nursing homes under State-Federal medical assistance programs were set today by the Departments of Public Health and Social Services. The new rates, effective July 1, will be in force until June 30, 1969.

Reimbursement for facilities providing skilled nursing care will be $14 a day; those providing basic nursing care will receive $11 a day. Current rates are paid at four levels, from $10 to $16 per patient day, depending on the level of care.

The new rates are interim fees pending studies during the year based on standardized cost accounting. State categorization of nursing homes under proposed administrative rules, and reassessment of levels of care required by individual patients.

The Department of Social Services administers the assistance programs, but the Department of Public Health, under contractual agreement, sets daily reimbursement rates.

(From the Michigan Report by the Gongwer News Service.)

Doctor-Nurse Conclave Planned

The MSMS Committee on Nursing will sponsor an invitational Conference for Physicians and Nurses with an emphasis on "Strengthening Nurse-Physician Relationships" at the Michigan Education Association Conference Center at St. Mary's Lake near Battle Creek, Sept. 4-5.

HELPS SMOKING COUNCIL PLAN GP WORKSHOP

Oscar D. Stryker, M.D., Mt. Clemens, will represent MSMS on the planning committee for the Michigan Academy of General Practice Workshop on Smoking and Related Disease at MSU October 20.

MAGP has requested MSMS and the other organizational members of the Michigan Council on Smoking and Health to help plan the physician workshop.

SWEENY COMPETES IN TV BOWL QUIZ

Michigan participant in the "Medical Bowl Quiz," one of the unique features at the recent AMA Convention in San Francisco, was Donald N. Sweeny, Jr., M.D., Detroit.

Four teams, of three members each, competed with one another in giving quick answers to questions in the field of politics on a televised show. "Our team lost by two points, and the team which beat us went on to win the contest, so we didn't feel too bad about our showing," Doctor Sweeny commented.

REPRESENTS MSMS

A. C. Stander, M.D., Saginaw, represented MSMS at the recent annual convention of the Michigan Hospital Association. Doctor Stander, Saginaw, is a member of The MSMS Council.

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 22-26, 1968. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

BRADLEY M. HARRIS, MD
President

ROBERT J. MASON, MD
Council Chairman

JAMES B. BLODGETT, MD
Speaker

VERNON V. BASS, MD
Vice Speaker

Attest:
Kenneth H. Johnson, MD, Secretary

Consumer Price Increases in Health Less Than Year Ago

In the past few years consumer prices have displayed an even sharper advance because of the greater importance in the index of the cost of personal services, retail distribution, and other activities with a high labor content. April consumer prices were 4.0% higher than a year earlier, in contrast to the advance of 2.5% in the preceding twelve months. The 1967 increase in consumer prices was the sharpest year-to-year rise in over 16 years.

Although hospital daily charges rose approximately 21.0% from March 1966 to March 1967, the following period (1967-68) only showed an increase of approximately 16.0%. Physicians' fees showed approximately a 10.0% rise during the period March 1966 to March 1967, however, the following period (1967-68) only showed a 4.0% increase.

In general, inflationary pressures are forecasted to persist in the months ahead with consumer prices continuing to increase.

Interested MSMS members can find detailed information in the June, 1968 issue of *Monthly Economic Letter,* published by the First National City Bank, New York; and from the monthly Consumer Price Index of the U. S. Bureau of Labor Statistics.

TO STUDY NURSING NEED

A joint study of Michigan's nursing education needs has been given approval of the State Board of Education. The study will be conducted by the Department of Medical Care Organization in the University of Michigan's School of Public Health and financed primarily through $50,000 of the Governor's Commission on Comprehensive Health Planning.

Leaves WSU Vice-Presidency, Scott to Travel, Teach Again

At the end of July, Gordon H. Scott, Ph.D., will leave for a three-month period of independent research in the fields of histology and electron microscopy at the University of British Columbia, following his recent retirement from the post of Vice-President for Medical School Development at Wayne State University.

"In his 23 years of distinguished service to the University," said WSU President William R. Keast upon announcing the retirement, "Doctor Scott has played a major part in making the Medical School one of the finest in the nation." After his work in British Columbia, Doctor Scott will continue his study for three months at the University of Washington, and for six months at Stanford University.

HE WILL THEN RETURN to Wayne State for a year of teaching in the department of anatomy. "I have been out of the classroom for more than 10 years and will look forward to going back," he commented.

Doctor Scott came to WSU in 1945 as a professor and chairman of the department of anatomy, served as Dean of the Medical School from 1950 to 1963, and from 1961 to the present he had served as Vice-President for Medical School Development.

DURING HIS TIME AT the school not only was the current building constructed, but definite plans were made for the new $56 million medical complex covering 25 acres of land near Grace and Harper Hospitals.

The groundbreaking last January of the $23.5 million Basic Science Building is considered by Doctor Scott as the "most gratifying experience" of his service to WSU.

"This made the relationship between the Detroit Medical Center and the University an assured thing," he said. "There was no turning back."

BESIDES HIS WORK AT the medical school, Doctor Scott served as president of the Michigan Health Council in 1963.

TO SURVEY FEES IN WAYNE COUNTY

MSMS Council recently approved a request from the Wayne County Medical Society that the MSMS Committee on Medical Socio-Economics, under the chairmanship of Dale L. Kessler, M.D., Grand Rapids, conduct a survey of fees by specialty and type of practice in Wayne County.

The survey will begin late this summer, will be of significant value to physicians not only in Wayne County, but throughout Michigan.

Council Selects Financial Board

The MSMS Council recently appointed a five member Board of Managers whose duty will be "to invest, re-invest, buy, sell, trade or otherwise, acquire, dispose of or manage Society assets assigned to its care with the objectives of achieving a combination of growth income and stability," according to the official Council minutes.

Appointed to the Board were MSMS Treasurer John R. Ylvisaker, M.D.; MSMS Finance Chairman Robert K. Whiteley, M.D.; C. Allen Payne, M.D., and Ross V. Taylor, M.D., members of The Council, and Thomas H. Wagner, investment counselor.

The Board was authorized by the special session of the House of Delegates.

Emergency Care Plan Tested?

The medical staff of every Michigan hospital should take the leadership to be sure that the hospital emergency medical care plan has had a recent trial run.

That contention is being voiced by The MSMS Council and the MSMS Committee on Public Relations in communications to every component medical society. The need for preparedness was explained in an editorial in the July issue of *Michigan Medicine* by Brock E. Brush, M.D., MSMS PR chairman.

Chorioretinitis: Its Etiology and Therapy

Abstract: Chorioretinitis is a major cause of blindness in the United States today. The usually obscure etiology of this disorder frequently requires a multispecialty approach to the problem. This presentation discusses some of the currently prevailing concepts of the cause and treatment of chorioretinitis and suggests a program of etiologic evaluation.

BY CONRAD L. GILES, M.D.
DETROIT

Inflammatory diseases of the eye account for more than 10 per cent of all blindness in the United States. Chorioretinitis or inflammation involving either the chorid or retina is responsible for nearly half of these lesions. Since the evaluation of patients with chorioretinal inflammation frequently involves several specialists, an understanding by all physicians of the current ophthalmologic management of this entity is obviously important. This paper will discuss some of the more important aspects of the etiology and therapy of this disease.

Because the nature of the visual process precludes the usual etiologic investigation of inflammatory processes, the clinician is severely handicapped in his attempt to isolate specific pathogens. Indirect laboratory and clinical investigation must be employed since biopsy or culture of the inflammatory focus will result in the loss of the eye. Although the microscopic examination of enucleated globes has proven significant in suggesting possible etiologies and avenues for further research, this method of evaluation has little direct value in the clinical approach to a given inflamed eye. In arriving at a presumptive diagnosis the clinician must therefore depend upon blood studies, skin tests, radiologic examinations, urinalysis and stool preparations for help. With these diagnostic tools it is possible to suggest an etiology in approximately 50 per cent of all patients with chorioretinitis.

PROVEN AND COMMON ETIOLOGIC AGENTS

TOXOPLASMOSIS is the most common presumptive diagnosis recognized in posterior uveitis at the present time. Toxoplasma gondii, an intracellular parasite is involved in two separate clinical syndromes: congenital and acquired toxoplasmosis. Central and peripheral chorioretinitis is seen in both groups of affected patients (Figure 1). The diagnosis is based on a positive toxoplasmin skin test and/or confirming serologic testing (methylene — blue dye study of Sabin and Feldman or hemagglutination) with the clinical picture of an exudative chorioretinite.

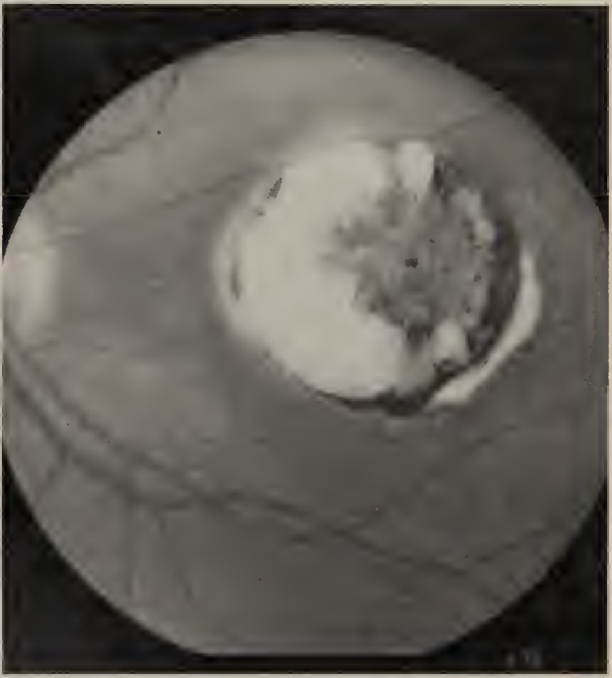

FIGURE 1: Macular chorioretinitis in 14-year-old girl with normal visual acuity and healed peripheral lesions in the contralateral eye. Sabin-Feldman titer positive 1:1024, positive toxoplasmin skin test both present.

The author is a clinical instructor in the Department of Ophthalmology, University of Michigan and Wayne State University.

SARCOID — Although involvement of the anterior segment of the eye with uveitis is more common than chorioretinitis, the characteristic fundus picture (Figure 2) in association with the systemic disease permits the clinician to diagnose another small segment of intraocular inflammation.

SYPHILLIS can involve the choroid and retina in both congenital and acquired syphillis. The disease may be either disseminated or localized and show large atrophic areas of retinal destruction. (Figure 3) The recent use of the FTA absorption study in the diagnosis of ocular syphillis suggests that a larger percentage of posterior uveal retinal disease is on a luetic basis than previously thought.

TUBERCULOSIS, unless miliary in type, is probably a very rare cause of posterior uveitis. Isolated cases have been reported and the diagnosis must rest upon the very tenuous basis of a positive tuberculin skin test in the presence of chorioretinitis.

TOXOCARA LARVAE are the most important agents involved in nematode infestation of the eye. Isolated posterior retinal lesions and vitreous abscesses, as well as iridocyclitis can be produced by this larvae. Skin testing and serologic data are unreliable and the diagnosis rests on the clinical appearance of the lesions in the pediatric age group.

UNPROVEN AND CURRENTLY FASHIONABLE ETIOLOGIES

Fashions are not limited to the haute couture of Paris and New York and choriortinitis, along with all disease of obscure etiology, has its fashions.

HISTOPLASMOSIS is currently the most widely unproven diagnosed cause of chorioretinitis. The characteristic lesion (Figure 4) is seen in a high percentage of positive histoplasmin skin reactors. This forms the basis of the diagnosis.

AUTOIMMUNE — For several decades the possibility of hypersensitivity and allergic phenomena has been suggested as an important cause of

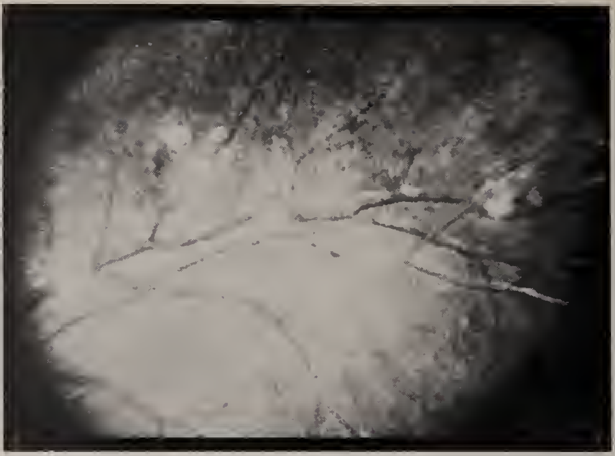

FIGURE 2: Retinal sarcoidosis with characteristic periphlebitic lesions referred to as "candlewax droppings" in the ophthalmic literature.

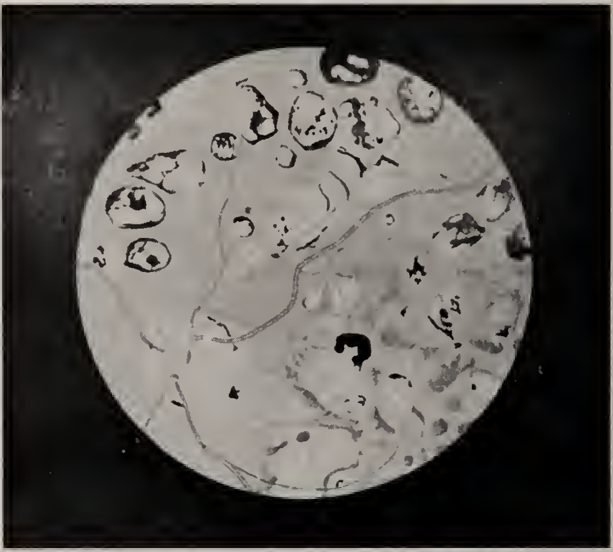

FIGURE 3: Disseminated, atrophic, healed areas of chorioretinal destruction in eye of patient with acquired syphillis.

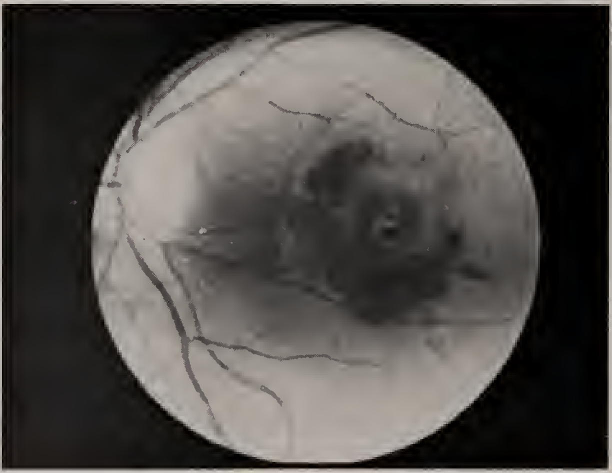

FIGURE 4: Central cystic macular elevation with surrounding collarette of hemorrhages in 35-year-old male. A positive histoplasmin skin test, negative complement fixation and chest film were present.

chorioretinitis. The significant clinical improvement following the use of antimetabolite therapy in patients with uveitis has increased the interest in this area though, once again, specific proof is lacking.

PROVEN BUT OBSCURE ETIOLOGIES

Several systemic diseases have as their components the sporadic occurrence of chorioretinitis. When the chorioretinitis occurs during the active phase of such an illness, the diagnosis, although once again presumptive is relatively simple. Unfortunately the temporal relationship between the uveal and systemic manifestations of the disease is variable. The following is a list of such diseases and is mentioned largely for completeness since lack of space and the relative obscurity of these entities in the United States does not permit a detailed discussion of each etiology.

a. Cytomegalic inclusion disease
b. Leptospirosis
c. Leprosy
d. Blastomycosis
e. Coccidiomycosis
f. Candidiasis
g. Cysticercosis
h. Onchoceraciasis
i. Brucellosis

ETIOLOGIC EVALUATION

The enormous task of ruling out all of the possible known causes of chorioretinitis in a given patient is expensive, time-consuming, unpractical and probably impossible. It is therefore necessary to formulate a pragmatic, somewhat flexible etiologic program in an attempt to isolate the etiology of chorioretinitis in as many patients as possible. The following program has been evolved to fill this need.

1. General physical examination by the generalist, pediatrician or internist to determine any associated systemic disease.
2. Skin testing — hystoplasmin, toxoplasmin, tuberculin and in endemic areas coccidioiden antigens are placed.
3. Blood studies should include a serological test for syphillis (FTA absorption), the complement fixation studies to histoplasmosis, coccidioidomycosis, blastomycosis and brucella hemagglutination and total serum protein with A/G ratio.
4. X-ray examination of the chest.
5. Stool examinations for ova and parasites in selected patients.

TREATMENT OF CHORIORETINITIS

The cornerstone of treatment of chorioretinitis is systemic corticosteroids. The use of this nonspecific anti-inflammatory agent is the only drug used in those patients in whom no etiology is found. Where specific presumptive etiologies are detected, appropriate chemotherapy is added to the corticosteroids.

Toxoplasmic chorioretinitis responds to Pyrimethamine (Daraprim-Burroughs-Wellcome) sulfadiazine and folinic acid (Leukovorin, Lederle). Large doses of penicillin and ampicillin are given to patients with luetic chorioretinitis while isonicotinic acid hydrazide (INAH) either alone or in combination with streptomycin and/or paraamino salicylic acid (PAS) should be employed in presumptive tuberculosis chorioretinitis. Thiabendazole is indicated in selected cases of toxocariasis and the indicated antimicrobial agents should be administered when any of the more obscure etiologic entities is suggested.

SUMMARY AND CONCLUSIONS

The etiology of chorioretinitis is frequently obscure. Because of the blinding potential of this inflammation, however, the ophthalmologist, together with his medical colleagues is commited to thoroughly evaluate these patients. The author has presented some current concepts concerning this entity and has suggested a program of etiologic evaluation based on currently available information. ☐

Editorial Comment:

As the author points out, Chorioretinitis still escapes etiological diagnosis in approximately 50% of the cases. The author has outlined an excellent scheme for the other 50%. Unfortunately the Generalist, Internist and Ophthalmologist will still rack their brains etiologically and therapeutically in the residue. The approach given by the author will certainly help those who have to cope with this problem. JWM.

Fetal Electrocardiography In Labor: A New Scalp Electrode

BY GEORGE E. LA CROIX, M.D.
DETROIT

Electronic monitoring of the fetal heart during labor expedites the early diagnosis of fetal distress and serves as a guide for its correction or termination by appropriate intervention. Experience suggests that intrapartum and perinatal loss may be decreased by wider application of continuous monitoring particularly in pregnancies at "risk."[1, 2] Correlation has been demonstrated between the fetal heart rate, acid-base status of scalp or cord blood, and the Apgar score.[1, 2, 3]

Sound and electrocardiography are popular approaches to clinical monitoring, but have serious limitations. Techniques utilizing multiplication of sound frequency and filtration of noise are superior to sound amplification alone,[4] but remain vulnerable to the noise of contracting uterine muscle and patient agitation. Experience with the fetal cardiac sound complexes is as yet inadequate for meaningful interpretation. Fetal electrocardiography secured through the abdominal placement of electrodes produces mixed maternal and fetal signals. Cancellation of the maternal signal is required by additional instrumentation before electronic counting can be employed. Under the best of circumstances, only the QRS wave of the FECG is identifiable, limiting its diagnostic value. In addition, the fetal signal may be entirely obliterated by the extraneous noise of the contracting abdominal and uterine muscle of the parturient in active labor.

Electrocardiographic techniques in which one or more electrodes make contact with the fetus produce a strong fetal signal. Resulting FECGs have minimal or absent maternal signal contamination and are therefore immediately suitable for electronic rate meters. Occasionally, detail is of sufficient clarity to permit analysis of the fetal electrocardiogram.[5] In labor, the presenting part of the fetus provides a point to which electrodes may be secured. Membranes must be ruptured, limiting such monitoring to the active phase of labor. Several types of electrodes consisting of prong-like, suction cup or modified skin clip varieties have been described for this purpose, but possess individual weaknesses which have limited their clinical usefulness.[5-9] Some are bulky or rigid, difficult to apply, require special aptitude, applicators or endoscopes for insertion, connectors and additional ground wires to the maternal thigh or ankle.[5-9]

A NEW ELECTRODE is described which eliminates many of the undesirable features of other types. Trial in over 150 patients has confirmed its safety, reliability, simplicity, ease of application, and clinical usefulness.

THE ELECTRODE

Figures 1, 2 illustrate the electrode. The negative electrode is a fine silver plated angle hook, similar in calibre to a 25-gage needle. The positive pole located one centimeter distal to it consists of a pure silver wire wound twice around the polyolefin jacket. Two fine wires within a continous tinned copper shield conduct the fetal cardiac potential from the two electrodes. The electrical circuit is completed through the vaginal secretions and amniotic fluid. The external shielding serves as an effective ground by continuous contact with the vaginal mucosa.

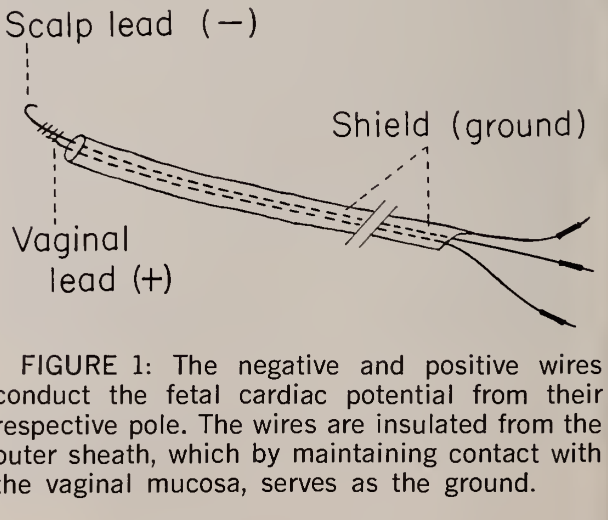

FIGURE 1: The negative and positive wires conduct the fetal cardiac potential from their respective pole. The wires are insulated from the outer sheath, which by maintaining contact with the vaginal mucosa, serves as the ground.

The author is associated with the Department of Gynecology and Obstetrics of the Wayne State University School of Medicine.

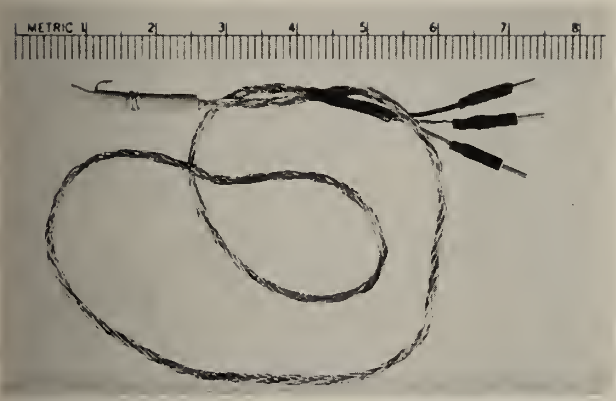

FIGURE 2: The leads are composed of fine flexible wires of 12-inch length. The overshoot of the polyolefin jacket helps to prevent motion of the electrode. The 3 micro connectors facilitate rapid connection to a lightweight patient cable.

CONSTRUCTION MATERIALS

All materials utilized in the construction of the electrode are available through local electronic and jewelry stores. The angle hooks are silver plated by a local electroplating concern.

1. #32, 2 conductor shielded Belden wire, #8429.
2. Silver wire, pure 26 gage.
3. Micro connectors, Amphenol, Reliatac-PO2.
4. Polyolefin tubing — Alpha F.I.T. — 300 — 1/8″ brown.
5. Shrink tubing — Alpha F.I.T. — 105 — 1/16″ white.
6. Angle hooks — Mustad-Viking — No. 94840 — #16 (extra fine).
7. Epoxy glue (Elmers).
8. Clear epoxy varnish.

METHOD OF CONSTRUCTION

The external shielding is stripped back one inch at either end of a 14-inch segment of wire, the excess shielding wound tightly at the distal end, and clipped off at the electrode end. Micro connectors are soldered to the shielding and the two exposed wires. A ½-inch segment of 1/16-inch white Alpha tubing is then heat shrunk over each solder junction for added durability. Attention is then directed to the construction of the electrode. The eye of the angle hook is removed, and the hook soldered to the black wire (negative pole). A 1½-inch segment of 26-gage silver wire is soldered to the red wire (positive pole). Both junctions are coated with epoxy glue. A one-inch segment of polyolefin tubing is perforated with a large needle at the ¾ and ½-inch mark, placing the holes at right angle to each other. The angle hook is inserted into the tubing and then through the ¾-inch opening. The silver wire is introduced through the opening at the ½-inch mark. The tubing is then heat shrunk forming the polyolefin jacket. The silver wire is wound twice tightly around the jacket one centimeter distal to the angle hook. The entire electrode — excluding the tip of the hook — is coated with clear epoxy varnish, air-dried and oven-baked at 200°F for one hour. The silver wire is lightly filed over a small area to expose the silver.

TEST PROCEDURES

Electrodes are tested prior to use for polarization noise and uniformity as outlined by Hon.[5] The response of the electrode when immersed in .9% saline in a shielded enclosure and tested by a suitably sensitive preamplifier generally reflects the noise level encountered in the in vivo studies. Electrodes are tested only at rest since the external shielding produces artifacts with agitation not seen in clinical use. An electrode with baseline drift or transient spikes of less than 25 microvolts is suitable for fetal electrocardiography. Excessive noise may be eliminated or decreased to an acceptable level by lightly electrochloriding the electrodes in .9% NaCL solution. Figure 3 illustrates the effect of electrochloriding. Any electrode with shorting between wires, lack of electrical continuity or excessive noise is discarded. Figure 4 illustrates the clarity of the FECG.

The amplitude of the FECG in 50 patients is illustrated in Figure 5. The QRS wave has ranged from 75 uv. to 800 uv. with the average 250 uv.

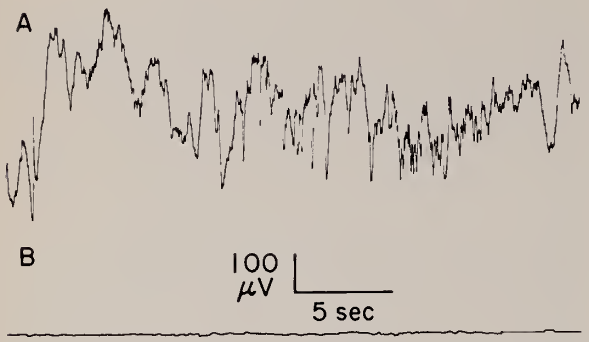

FIGURE 3A: Basic polarization noise of the Ag-AgC1 electrode tested in .9% saline. The drift and spikes seen in the test environment may be reflected in the FECG. Paper speed 5 mm. per second. Recorded on a Sanborn Recorder - Model 2100.

FIGURE 3B: Note the improvement in the noise level when the positive and negative electrodes are electrochlorided for one minute at 1½ volts. Paper speed 5 mm. per second. 100 uv. calibration is the same in A and B.

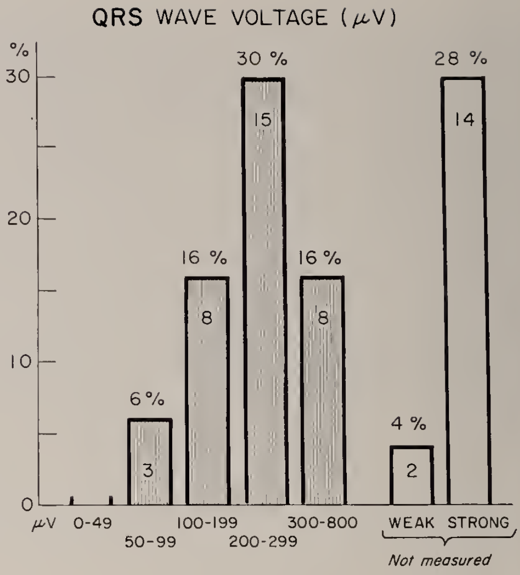

FIGURE 5: The distribution of fetal electrocardiograms in 50 patients according to the amplitude of the QRS wave. The weak signals (under 200 uv.) and strong signals (over 200 uv.) were calibrated by visual estimation of the oscilloscope image. The remainder were accurately calibrated from permanent records.

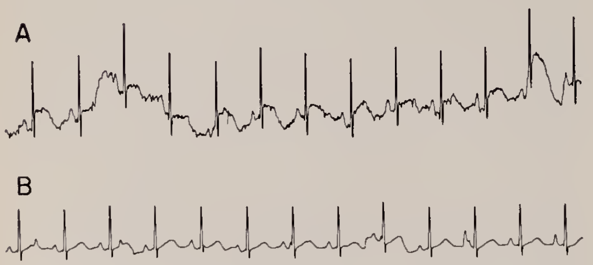

FIGURE 4A: If the electrodes are not electrochlorided, a "noisy" FECG may result. The QRS wave measures 250 uv. Paper speed 25 mm. per second. This FECG is suitable for cardiotachometry, but of less value for analysis of FECG components.

FIGURE 4B: A "quiet" FECG followed electrochloriding the positive and negative electrodes. The QRS wave measures 400 uv. Paper speed 25 mm. per second.

CLINICAL USE

The electrode has been inserted at virtually any stage, station (minus 3 to plus 3) or dilation in labor which permits passage of the uterine packing forcep. Application usually requires less than one minute. The fetal membranes must have been ruptured prior to application or amniotomy is performed as soon as obstetrical conditions become favorable. The distal polyolefin jacket is grasped by the clamp, introduced under aseptic precautions in bed using two fingers of the opposite hand as a guide (Fig. 6). The angle hook is placed in apposition to, and gently set into the scalp, taking care to avoid suture lines or fontanelles. The small diameter of the hook prevents penetration deeper than 2 to 3 millimeters. Usually applied to the fetal vertex, it has produced clean tracings in five infants presenting by the breech. No injury has occurred to mother or infant in over 150 applications.

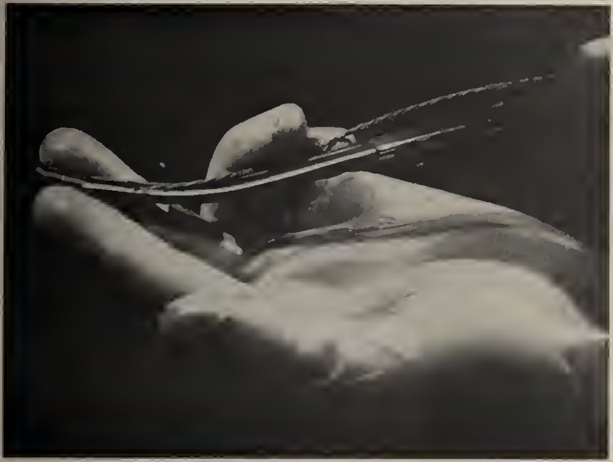

FIGURE 6: The distal end of the polyolefin jacket is grasped by the uterine packing forceps, introduced vaginally under aseptic precautions, using the fingers as a guide.

Although the best results with an electrode are obtained on the first occasion, many have been used four to five times. Special care is not necessary when cardiotachometry alone is contemplated, but thorough cleansing, retesting and chloriding are desirable for optimal detail of the FECG. Conventional autoclaving will not injure the electrode.

COMMENT

Investigation of the fetal electrocardiogram and its application for electronic heart rate counting have clinical and research value. The small size of the angle hook electrode makes possible its use from early in the first stage of labor through the hazards of the first and second stages when the infant is at major risk. The fetal cardiac complex may be permanently recorded for analysis, displayed on an oscilloscope, or used to trigger a cardiotachometer or suitable audio visual system.

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Editorial Note:

Fetal monitoring during labor will do a great deal to lower fetal mortality, especially in such cases as prolonged and difficult labor as well as prolapsed cord. People in various centers are working on fetal oximeters but as yet I do not know of any practical set up. The author presents a simple and apparently excellent method for fetal ECG monitoring. It is to be hoped that many hospitals will adopt this procedure. JWM

COMING EVENTS

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

COMMUNITY HEALTH WEEK PLANNED FOR OCTOBER

MSMS plans for Community Health Week, October 20-26, are rapidly developing. MSMS is planning a program for a statewide meeting to focus on the major problems in medical service to rural areas of Michigan, the AMA rural emergency care plan, the problems of health manpower, and other related topics. The meeting is an example of how Community Health Week, Oct. 20-26, can be adopted to focus on local needs.

Health Careers is one of three topics suggested by the American Medical Association, the others are drug abuse and physical fitness.

A promotion kit is available to help county societies prepare for Community Health Week. Copies can be obtained from MSMS headquarters.

The Michigan Health Council and the Michigan Association of the Professions are cooperating.

MICHIGAN MEDISCENE

Aug. 21 — The Council, MSMS Headquarters, East Lansing (Tentative)

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit

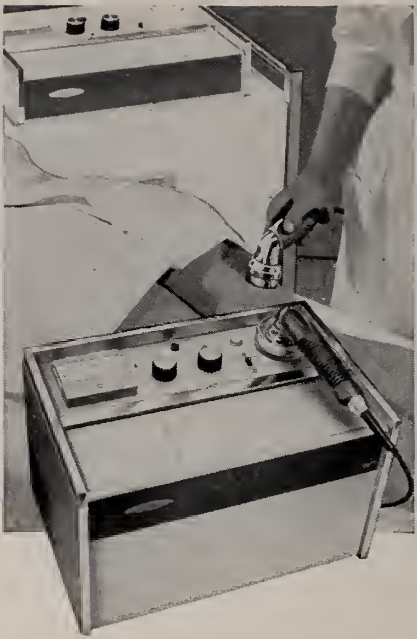
Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit



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Say you saw it in Michigan Medicine

These Firms Make '68 Annual Session Possible without a Registration Fee

One of the colorful and educational aspects of the MSMS Annual Session in Detroit this September will be the interesting array of exhibits.

MSMS leaders say, "Take time to inspect each one – not just a casual look – but a real indepth study. You will be surprised at the wealth of new information they will offer you."

Following is a list of the firms who will be presenting displays at the 1968 MSMS Annual Session. Doctors are urged to make a special effort to visit each booth to personally express appreciation and to ask questions.

Income from the leasing of exhibit space makes it possible for MSMS to present its excellent Annual Scientific Session without a registration fee.

The intermission periods between scientific sessions will provide excellent opportunities to study the exhibition. The registration desk, meeting rooms, and exhibits will be conveniently located on the same floor as the meetings.

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

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- Standard Process Laboratories
- Ben P. Stratton Agency, Inc.
- The Stuart Company
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- Syntex Laboratories, Inc.
- S. J. Tutag & Company
- United States Tobacco Company
- Wallace Laboratories
- Warren-Teed Products Company
- Westwood Pharmaceuticals
- Winthrop Laboratories, Inc.

Of Partnerships and Politics

BY D. BONTA HISCOE, M.D.
LANSING

A good and rather outspoken friend of mine recently cut off a conversation on the general subject of medicine's future by saying, "I'm sick to death of hearing about what they'll do if we don't."

This physician happens to be more well-informed than the average. He knows that medicine is now considered a right and not a privilege. He is aware of the recent great progress in medicine and the revolution of rising expectations. He is aware of the recent avalanche of medical legislation — Medicare, Heart Disease, Cancer and Stroke, and Comprehensive Planning.

Inside he knows that his remark only ends the conversation — it doesn't solve the problem.

The best answer I know to his attitude was presented by Dr. Wallace S. Sayer, Chairman of the Department of Public Law and Government at Columbia University, at a recent meeting sponsored by the AMA. Speaking about the American political system as an environment in which we must work, he stated: "What I would like to do is to welcome you to a world you've been shy about entering, but in which you have now arrived, and to reassure you that the rules of survival can be learned and that the mortality rate is low." He pointed out that the decision-making system of our country is pluralistic, that there is room for all, and that there are many centers of power competing with each other. He said, "When it comes to important public policy, politics are inescapable. Decisions are reached in this system . . . . . by bargaining among competing centers of power. 'Bargaining', if not quite a respectable word to this audience, is an indispensable skill in the system. One way to unlock the mysteries of what happened to the A.M.A. in the last ten years, might be to say that an indisposition to bargain means defeat. A successful participant in this system must be prepared to bargain." He then explained that all decisions are tentative, never final, and that an essential part of bargaining in this system is alliance-building.[1]

In other words, if you're in the water, whether you're fish, fowl or mammal, you must swim.

The background for my remarks has already been well laid by James T. Howell, M.D., at last year's MHA Medical Staff, Trustees and Administration Forum at Mackinac Island in June of 1967. He said then that both doctors and hospitals are dedicated to the eradication of human ills, and to maintaining freedom from direct controls. If either one falls under central control, so does the other. And yet, doctors and hospitals are not united in their efforts.[2] May I suggest some practical first steps to accomplish this end?

WHAT'S HAPPENING

Our medical care system has recently been picked apart, studied, analyzed, and evaluated by a new breed called "problem-solvers", whose unsolicited attention is both flattering and disconcerting.

In the past few years extensive studies have been carried out by many individuals and agencies who have worked under a variety of auspices. Their principal questions were: "How is the job being done?"; "Is the whole need being met?"; "Can it be done better, now, and in the future?"

Some of their reports will have considerable bearing on the future of medicine. A few of the most significant reports are:

The Folsom Report — entitled, "Health Is A Community Affair."[3]

The Coggeshall Report, focusing on medical education and the future.[4]

The author, president of the Health Planning Council of Michigan, presented these remarks at the 1968 Medical Staff — Trustee — Administrator Forum at Boyne Mountain Lodge.

The Millis Report, which introduced the term, "primary physician."[5]

The report of the National Advisory Commission on Health Manpower, released in 1967.[6]

The immediate reaction of those being poked and probed is similar to that of a patient having a barium enema. He would like to disparage, discredit and dismiss the whole thing as unnecessary tampering or meddling. This is, of course, unbelievably short-sighted.

CERTAIN POINTS MUST BE CONCEDED

First, there are problems that have stimulated these studies. We may not agree as to how many there are or as to their significance, but there are problems.

Second, there are enormous pressures to search for answers. Manpower and facilities are in short supply and the demand is great, creating, in effect, a demand-pull type of medical inflation. In order to cope with the current and inevitable increase in cost, the organized consumers (the government, labor, business and the insurance companies) are expressing firm demands for efficiency and cost control. Some things new, different and better, are expected.

Third, legislation has been passed, which shows that they mean business. More will come.

Fourth, we must concede that these people (doing the studies) are highly intelligent, thoughtful, and imaginative. They represent disciplines and approaches foreign to the medical community. They may on occasion be misguided or unenlightened, but they are smart.

CONCLUSIONS OF THE CRITICS

FIRST, they say our medical care system today is actually a "non-system."[7] A recent *New England Journal of Medicine* editorial succinctly puts it this way: In medical care "vast and fruitful attention has been paid to research and development, but marketing, sales and packaging have been sadly neglected."[8] There should be a system.

SECOND, they say that the community interest should take precedence over any special interest group, be it hospital, physician, research institution or medical school.

THIRD, the scope of medical care should be increased to include total health care, rather than remain chiefly crisis-oriented.

FOURTH, the primary center for medical care on the local level should be the hospital rather than the physician's office.

FIFTH, though the types and roles of physicians in the future have not been well-defined, physicians are being firmly encouraged to develop various types of coordinated or group practice, and to utilize ancillary help.

So much for the views of our critics. Let me now respond with my own personal views as to how we, doctors and hospitals together, should respond to these challenges.

UNITING THE EFFORTS

Physicians are essential in medical care, but they cannot practice today's medicine in a vacuum. They need hospitals in order to ply their trade satisfactorily. On the other hand, hospitals are not independent health care units either — they need doctors. I know of very few hospital administrators who could practice good medicine, and there are many bankers and salesmen who will attest that physicians are wretched businessmen.

In past years physicians and hospital administrations have developed a guarded relationship by carefully defining their respective areas of responsibility. So long as each did his job well, the hospital thrived, and its position in the community was assured. But in the future, if current thinking prevails, the autonomy of each hospital is threatened with integration into a community-wide system, while at the same time, the sharp distinctions between hospital administration and medical practice are becoming blurred. As new regulations come from all directions, hospital administration is being given more responsibility for the quality and quantity of medical care. For example, hospitals are now legally liable for the medicine practiced within their walls. And while the hospitals are thus pushed into medical concerns, the Commission on Health Manpower has recommended "an increase in the physician's responsibility for the successful and economical management of the hospital operations" — that he have a financial stake in the management of the hospital, and be included on the boards of control!

It is clear, then, that physicians and administrators are actually both essential parts of a single organism. And it is time for them to function this way.

It is time for us to give up prejudices and animosities inherited from the past. These are luxuries we cannot afford. It is time to learn the rules of the new ball game. It is time to show some real initiative. It is time for medical societies and hospital associations at all levels to realize that by working together they can accomplish much more, both for their communities and for themselves.

Physicians' services account for about 25% of the health care dollar. Hospital expenditures account for 33%. If we include the drugs we dispense, about two-thirds of the medical care dollar passes through our hands. Together, we represent the system (or "non-system") as it is today, and we are responsible, in large part, for both its successes and its failures.

PARTNERSHIPS of all kinds are the "in" thing today. Congress recently named a bill, "Partnership in Health." College kids work like crazy at it. Why shouldn't we?

This combination would put together the "Doers" of medicine. If we could work out constructive and responsible common stands on major issues, we could have tremendous influence. Then within the medical system, we, the "Doers," could more effectively stand up to the planners, researchers and educators. In the political arena our voice would command more attention than the efforts of our separate trade associations. We could form a powerful nucleus for practical, reasonable and evolutionary change.

In actual fact, no one group, nor single partnership, will call the majority of the shots, much as we might like to. That's why even a partnership such as I propose should promptly build cooperative arrangements with the many other voluntary groups interested in the future of health care.

We are told that the ideal and ultimate solution should be a partnership between the whole voluntary sector and the government. If this be the case, I strongly urge that our half of the partnership be pulled together firmly and strongly, be solidly built and well stacked.

SUGGESTIONS

I feel that it is urgent to push this type of working coalition into being soon. I'm therefore going to take a few minutes to make a few firm and concrete suggestions.

On the national and state levels, dormant and atrophic liaison mechanisms should be shined up and reactivated. If they have vanished, active new liaison committees should be established — not to be polite and exchange platitudes — but to explore all areas and means of cooperative action. Speak to the delegates of your respective associations and give them a push.

In the meantime, County Medical Societies should incorporate the know-how of Hospital Administrators into their deliberations. Administrators should be an integral part of all hospital relations committees. Administrators should also be included as part-time members or consultants on other appropriate committees. The hospital regional associations should do the same thing on their part.

SPECIFICALLY, HERE are some things I think we can work on:

FIRST, continue to produce useful conferences such as this Staff, Trustees and Administrators Conference, developing understanding and new ideas.

SECOND, coordinate some public education programs, particularly those promoting health careers, discussions about current health matters, and public health.

THIRD, by combined effort, more effectively support (or challenge) new legislation.

FOURTH, cooperatively contest questionable court action in order to modify an influence with an ever-increasing impact on medical practice.

FIFTH, participate in planning efforts together, so that we can propose voluntary solutions to health care problems. The Health Manpower Commission Report acknowledges that the Federal Government alone is not big enough nor rich enough to solve the problems of health care for the whole country. They are anxious to share this responsibility, but the question has been, "with whom?"

When one looks at the strong competition — State Government and Regional Medical Programs — one quickly realizes that within the voluntary sector petty rivalries are stupid, irrational and self-defeating. The voluntary sector must rise to the challenge. The opportunity may be brief!

Representatives of the voluntary sector must demonstrate the foresight to support significant efforts; we must have the maturity to evaluate new ideas dispassionately; and we must demonstrate the stature and courage to carry out worthwhile ideas. Voluntary agencies are best able to maintain flexibility in the face of multiple problems. The mere presence of a strong united voluntary sector with its great intellectual and political resources would be certain to win a much more significant role in future planning.

The Health Planning Council of Michigan, appropriately supported and developed, could be a strong spokesman for our partnership, since it is supported not only by physicians and the hospital associations, but also includes other health-oriented groups and interested laymen. This organization's sole function is to promote local and regional planning, and in no way does it presume to dictate to nor supplant the local planners.

SIXTH is the area of common concern — money. Ironically, in the future we will have to protect medicine's share of the federal pot of gold. Currently, federal money is abundant. Hospital and physician income will be increasingly subsidized by government. Should social interest shift and other pressures threaten curtailment of this support, the protection of this subsidy on which future budgets, personal and hospital, will depend, will become an increasingly important project for everyone interested in health care.

CONCLUSION

The dictionary defines intelligence as "the ability to respond successfully to new situations." This offers a great challenge to our collective conceit.

Let's see to it that the integrated medicine of the future truly fills the patient's needs, and maintains flexibility in the process.

Let's accept the challenge. Think big. Work hard. Together.

And above all, let's see to it that we are at least co-captains of the comprehensive ship.

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The Need for Utilization Review

BY LOUIS F. HAYES, M.D.
VICE PRESIDENT, MEDICAL AFFAIRS
MICHIGAN BLUE SHIELD

A previous article published in *Michigan Medicine* dealt with the "what?" of utilization review. A quite simple definition was reached — measurement of the use of medical service. Equally as important, the objective was also defined — the best medical care for the most people at the lowest cost.

To attain a thorough understanding of utilization review (the ultimate objective of the planned series of articles) the next question to be answered is "Why?" What is the need for utilization review? What are the factors that compel us to this extracurricular task? Why the urgency?

FIRST, LET US IDENTIFY THE factors involved and then evaluate their influence. And, once again, let us simplify it as much as possible. The influencing factors are the product — medical services; the consumer — the patient; the provider — the physician and his allies; the third party — government, industry, labor, health insurance carriers; the environment — where the service is rendered; and the economics — the cost of the service. Each is highly contributory; taken all together they develop a strong case for the necessity of utilization review.

Medical service, the product, is not a static commodity. Over the years such services have increased in quantity and quality with a resultant increase in unit and total cost. The challenge is how to make these services available to all at reasonable cost. How can this be done if we have no means of measuring normal use?

More and more the consumer assumes an important role. Formerly docile and easily led, he is now educated and sophisticated, particularly in medical matters. He realizes the benefits of quality medical care and its contribution to his well-being and longevity. He is aware now of the advances in medicine and earnestly desires the best in care for himself and his family. He is willing to pay a good share of his income to fill his needs, but if he can't afford it, he wants help to do so.

HOW CAN HE BE assured of quality?

How can he be assured of reasonable cost?

Only if we have the capacity to measure can we assure him. Only if we have the capacity to measure can we identify his needs and solve the problems of distribution of services, making this quality care available to him.

The physician and his team face a dilemma. In the face of an increasing population and increasing doctor to patient ratio, how is he to deliver the service? How is he to make available the better quality, the greater quantity of care to his patients? His predicament cannot be solved unless he has a way to measure the quality, to evaluate the cost versus the need. Utilization review would provide some of the information needed for such decisions.

The ultimate interests of all third parties are the same — getting the most and best care at the lowest possible cost per person. Their spheres of influence vary, occasionally overlap, but the objective is the same. And their interest cannot be maligned — their dedication to the task and desire for fulfillment equals that of the patient and the doctor.

Government seeks to assist by subsidization, but in protecting tax must have concern for quality and availability. Health insurance carriers aid by administering the techniques of prepayment and risk sharing, but have the same fiscal responsibilities and the same concerns toward members as government has for taxpayers. Industry and labor are equally concerned and pragmatic. Industry pays out large sums, negotiated by labor, to purchase medical care. As practical businessmen, managers want the best product at the best price. But how can this be determined unless we measure?

Doctor Hayes, formerly of Gaylord, is now vice president, medical affairs of Michigan Blue Shield in Detroit. This is one of a series of articles.

ENVIRONMENTAL FACTORS are significant in their impact. The location of the patient may influence the quantity and quality of medical service available; strangely enough there is deprivation in both congested urban areas and remote rural areas. Here is a need for measurement. Yet another need is the measurement of the efficiency of the site of the service — the hospital, the office, the home.

The final factor to consider is that of economics. All medical service has some cost; additionally, even the most naive will recognize that the total cost of medical service is rising and honesty compels us to recognize that the unit cost of care is also rising. Perhaps this trend cannot be stopped, but surely it can be reasonably controlled. *We* of health care to discover what is "reasonable." As a result we could maximize the efficiency of the delivery of medical services in all environments, thereby keeping cost to a minimum.

IS THERE ANY DOUBT of the need?

Everyone (the provider, the patient, the public) has the same concern, the same objective; each has his own interest, his own concerns; all have something to contribute in attaining the goal. Economic facts and the needs of all dictate the need for cost control; social and geographic facts dictate the need for quantity control. And, though there are other factors, the best interests of the patients, the pursuit of excellence and the professional pride on the part of the physician dictates quality control. He has proven his ability in the past, he can in this instance.

Measurement — utilization review — is the tool that can aid. □

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FOUR-WEEK PERIOD ENDING JUNE 29, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	31	74	233	864
Whooping Cough	36	57	247	537
Diphtheria	0	0	0	0
Mumps	994	1,661	12,816	12,173
Scarlet Fever & Strep Sore Throat	491	646	6,596	8,942
Tetanus	0	1	2	2
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	181	119	1,059	1,050
Salmonellosis (Other than S. Typhi)	81	29	353	256
Typhoid Fever (S. Typhi)	0	0	0	4
Shigellosis	24	26	117	259
Aseptic Meningitis	2	10	26	19
Encephalitis	1	20	48	67
Meningococcic Meningitis	11	7	59	40
Influenzal Meningitis	5	2	31	23
Tuberculosis	214	180	1,425	1,482
Syphillis	326	401	2,784	2,993
Gonorrhea	1,215	1,317	8,280	8,226

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

ACTIVITIES, PROJECTS

PSYCHIATRY SOCIETY TO REPEAT COURSES

Beginning in September, the Michigan Society of Psychiatry and Neurology in conjunction with the Michigan Academy of General Practice again will offer its course in psychiatry for non-psychiatric physicians in several major cities around the state.

The nine-month course will end in May, 1969. It will be held on a given day of each month from 1:00 P.M. to 5:00 P.M.

This year the program will be open not only to physicians but also to psychologists, social workers, clergymen, nurses and other interested professionals. The program will emphasize principles and practice of psychological counselling and the management of emotional problems such as adolescents, marriage conflicts, hospitalized patients, psychosomatic and somopsychic disorders, neuroses, character disorders such as alcoholism, and some psychoses.

Physicians may obtain details from Leonard Rosenzweig, M.D., 515 Lakeside Drive, S.E., Grand Rapids, 49506. ☐

BOOK FIRM FOUNDATION HONORS EASTERN PROF

John Eager Howard, M.D., professor of medicine, Johns Hopkins University School of Medicine, received the Passano Foundation Award during the annual AMA meeting in San Francisco.

The Passano Foundation was established in 1945 to honor outstanding men of medical science in the United States. The Award of $5,000 is made yearly during the AMA convention. The Foundation is sustained by annual contributions from The Williams & Wilkins Company, a leading publisher of medical books and journals. ☐

MDPH Seeks Infants With Hearing Problems

Michigan physicians are being asked by the Michigan Department of Public Health to help identify and locate infants with profound hearing loss due to maternal rubella in early pregnancy.

According to a recent statistical projection made by the Department, 4,000 Michigan babies may have profound hearing loss resulting from the rubella epidemic which swept the country in the mid 60s, reaching a peak in Michigan during the years 1964-1966.

Theresa B. Haddy, M.D., Chief of the Division of Child Health at the Bureau of Maternal and Child Health, says that, "In the last year and a half over 400 infants with profound hearing loss have been identified. These range in age from 3 months to 3 years. A large proportion have positive histories of possible maternal rubella. This greatly increased incidence of profound hearing loss in early infancy suggests that Michigan babies were affected by the rubella epidemic."

"Early identification of hearing loss in infants is extremely important," she continues. "Carefully selected hearing aids and programs to stimulate the development of language and speech should be considered as early as possible."

"Local health departments," Doctor Haddy concludes, "or the Hearing and Speech Section of the Michigan Department of Public Health can assist with information regarding centers equipped and staffed to test the hearing of babies." ☐

STATE BIRTHS, DEATHS SHOW STEADY INCREASE

Both the number of births and deaths have increased in Michigan for 1967, as compared to 1966, according to provisional figures released by the Michigan Center for Health Statistics.

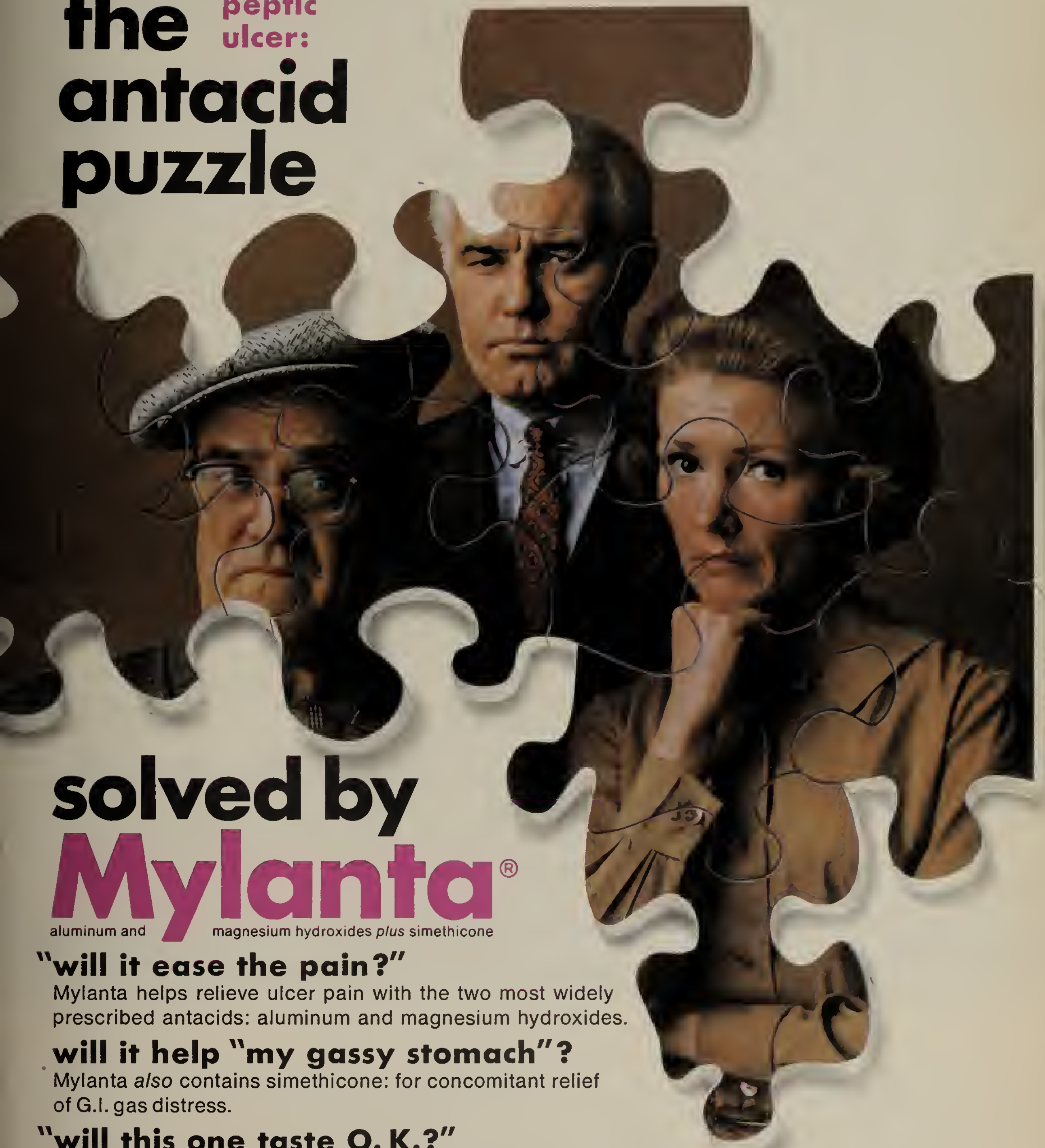
Comparing the two years, the causes of death have remained relatively the same — the big three of course being heart disease, cancer, and stroke, in that order.

There was a slight dip in the number of deaths due to accidents in 1967 as compared to 1966. ☐

1966		**1967**	
Births:	155,794	Births:	162,756
Deaths:	74,596	Deaths:	75,245
Causes of Death:		**Causes of Death:**	
1) Heart Disease	28,277	1) Heart Disease	28,642
2) Cancer	12,506	2) Cancer	12,999
3) Stroke	7,732	3) Stroke	7,834
4) Accidents	4,737	4) Accidents	4,470

In peptic ulcer:

the antacid puzzle



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aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic

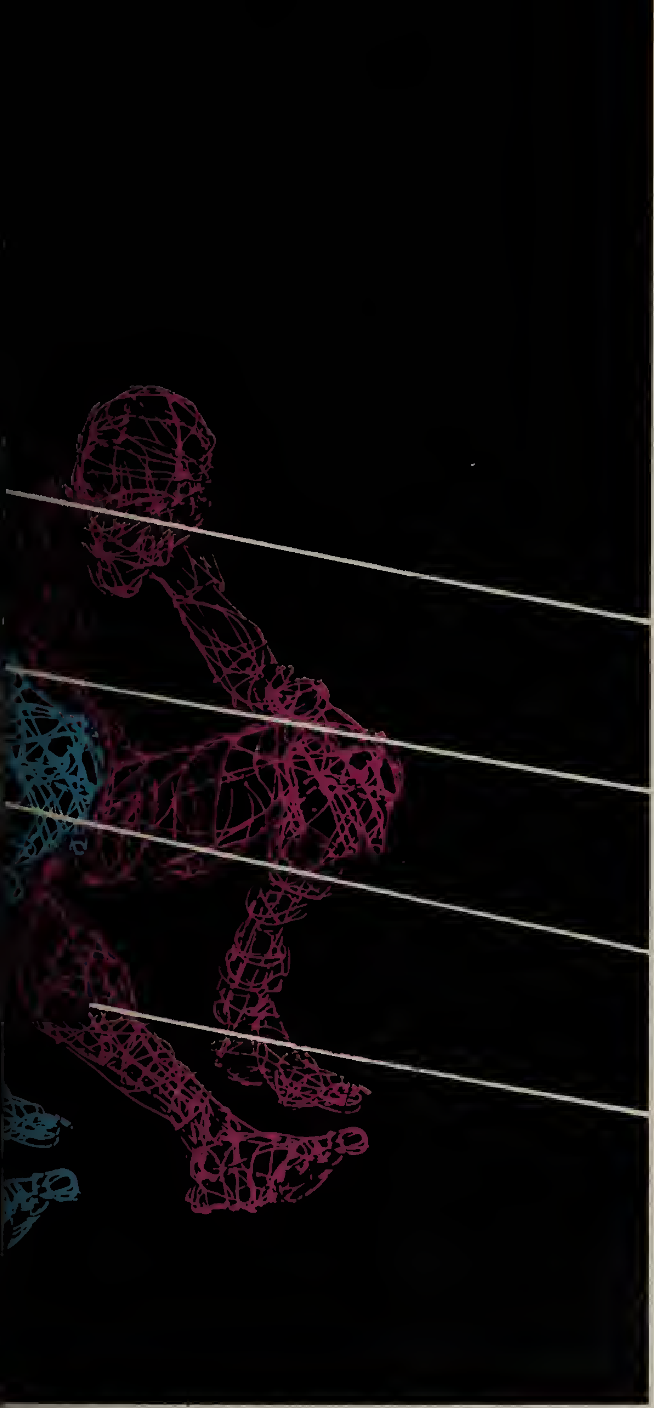
Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires approp
investigation to determine its cause or causes.
In pernicious anemia, the use of folic acid without adeq
vitamin B_{12} therapy may result in hematologic remission but
rological progression. Adequate doses of vitamin B_{12} (paren
or oral with potent intrinsic factor as in Trinsicon® [hema
concentrate with intrinsic factor, Lilly]) usually prevent, ha
improve the neurological changes.
As with all preparations containing intrinsic factor, resist
may develop in some cases of pernicious anemia to the pote
tion of absorption of physiological doses of vitamin B_{12}. If r
ance occurs, parenteral therapy, or oral therapy with so-c
massive doses of vitamin B_{12}, may be necessary. No single
men fits all cases, and the status of the patient observ
follow-up is the final criterion for adequacy of therapy. Pe



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are commended.

lverse Reactions: In rare instances, iron in therapeutic doses oduces gastro-intestinal reactions, such as diarrhea or constition. Reducing the dose and administering it with meals will inimize these effects.

In extremely rare instances, skin rash suggesting allergy has llowed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after al administration of folic acid.

osage: One Pulvule twice a day. (Two Pulvules daily produce a andard response in the average uncomplicated case of pernious anemia.)

ow Supplied: Pulvules Trinsicon® (hematinic concentrate with trinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information
available to physicians
upon request.
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Now . . . a new
alternate salicylate product
from Warren-Teed

Magan®
(magnesium salicylate, W-T)

magan®
an alternate salicylate

particularly offered for the management of those chronic arthritic and rheumatic patients with gastrointestinal intolerance to aspirin and other salicylates

pain relief comparable to aspirin

Magan may provide effective salicylate therapy for a substantial number of your patients who cannot tolerate other salicylates because of gastrointestinal irritation.

Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan®

(Magnesium Salicylate, W-T)

microphotograph of magnesium salicylate crystals

Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

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Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

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Enduron: (methyclothiazide) A basic building block for mild hypertensives

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Tablets
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Enduron provides an excellent starting therapy. Your patient’s sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

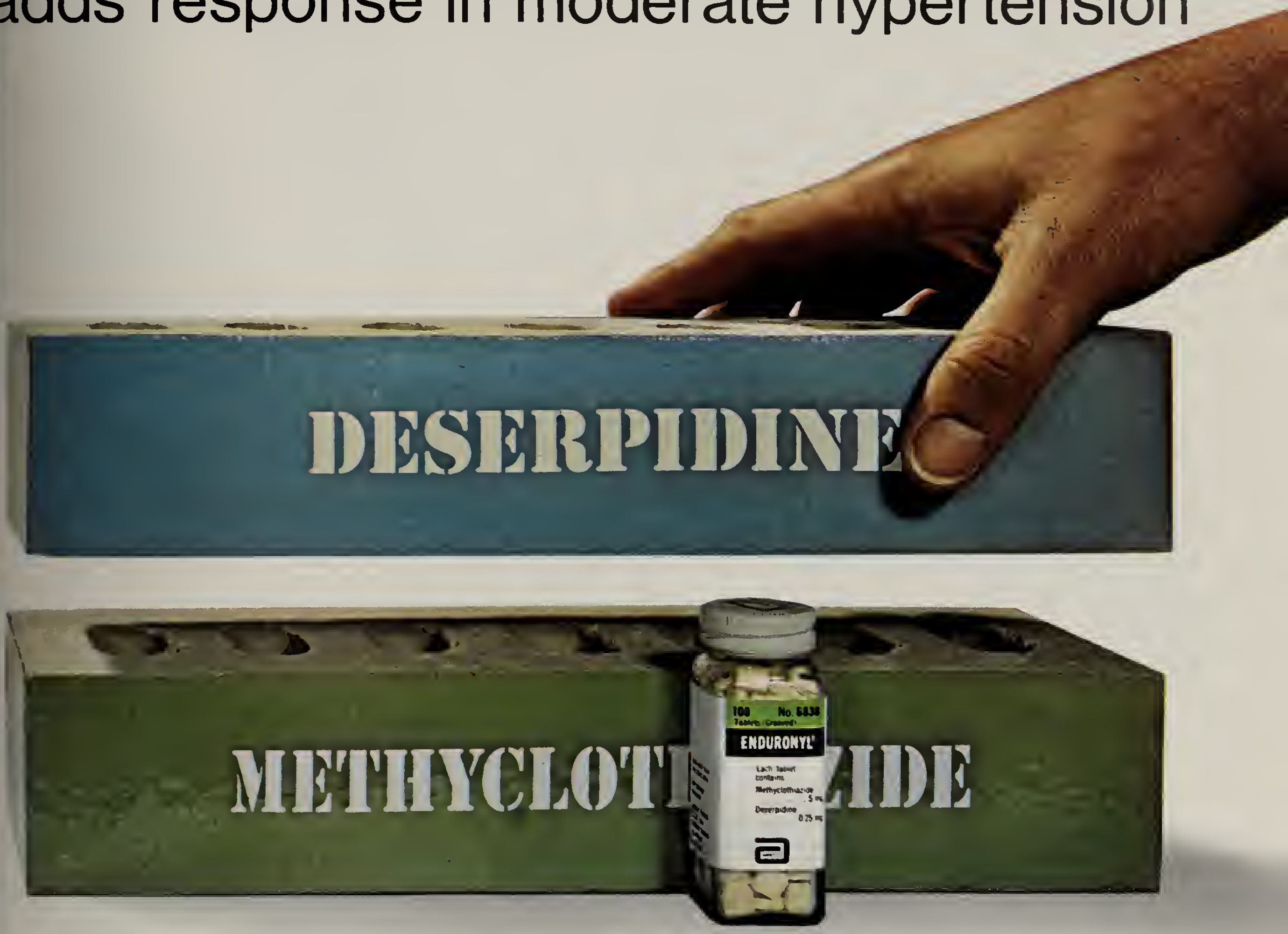
Use Enduron as a basic therapy in patients with mild to mod erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day
ENDURON®
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVER

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD
TO
MODERATE
TO
SEVERE

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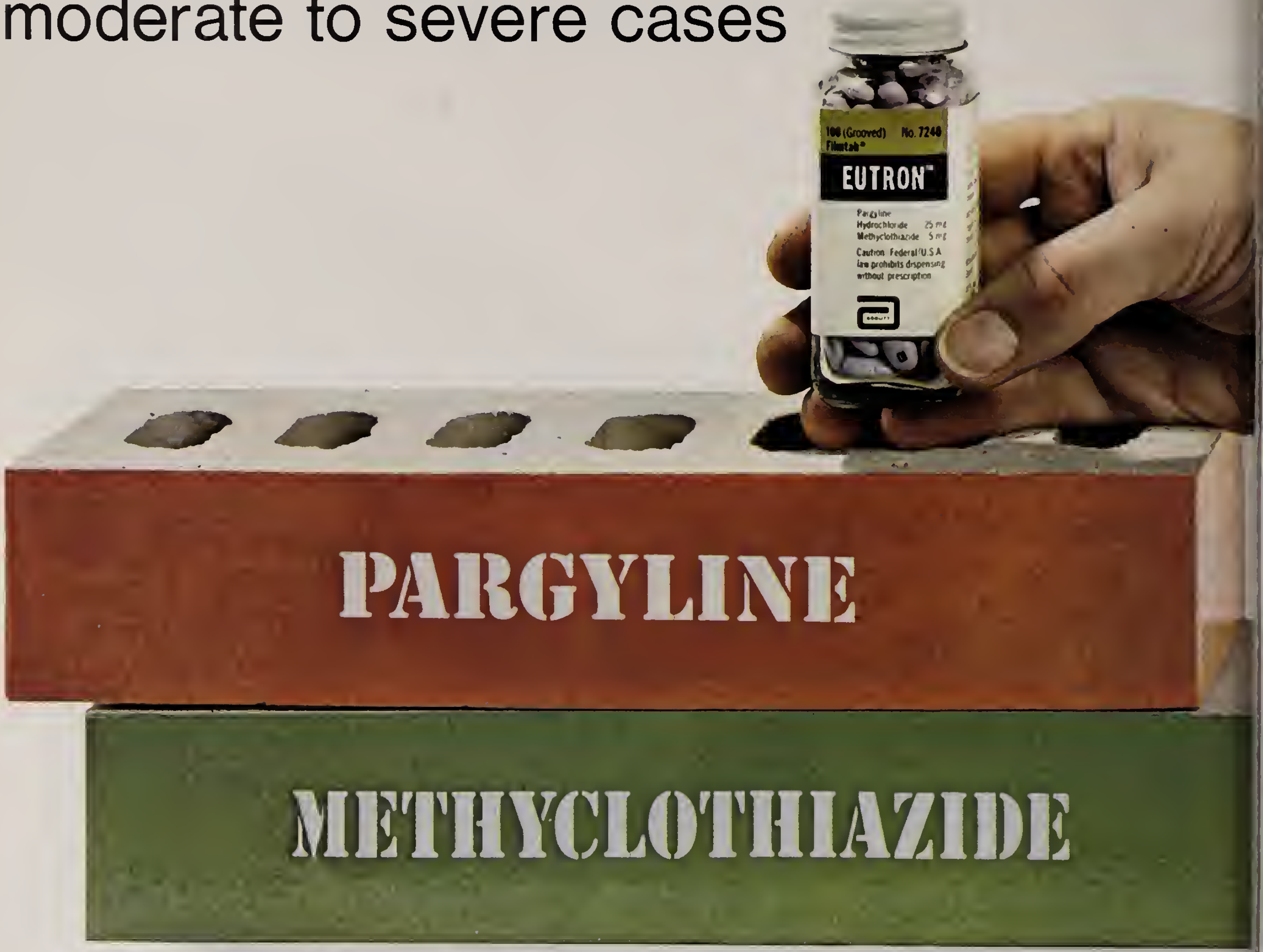
Eutron: A unique combination for handling moderate to severe cases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Pargyline Hydrochloride 25 mg
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Caution Federal/U.S.A. law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

MILD TO MODERATE TO SEVERE

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804436R

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State Supreme Court Rules MD Not Permitted To Testify in DO Suit

(Editor's Note: The following article is quoted from the AMA Citation newsletter of June 15, 1968, prepared by the AMA Law Department.)

In a patient's suit against an osteopath for injuries caused by his allegedly negligent performance of an oophorectomy, a trial court properly refused to permit an allopathic physician to testify as to the standards of osteopathic practice because the physician expressly denied having any knowledge as to the standards applicable to osteopathy. If he had knowledge of such standards, the Michigan Supreme Court said, he would have been qualified to testify. A new trial was ordered because of the trial court's refusal to allow the patient to call as an adverse witness a second osteopath, who had assisted in the operation.

The patient's right ureter was cut during the operation. The osteopath inserted a catheter in the opening of the ureter and closed the opening with sutures. The osteopath had intended leaving a Peurose drain in place over the urethral repair, but he overlooked doing so until the wound was completely closed. He decided not to reopen the abdomen, because he considered the urethral repair secure. When a systoscopic examination disclosed that the ureter's peristaltic action was expelling the catheter, the catheter was removed with forceps and a Foley catheter placed in the urinary bladder. A blockage of the ureter developed, which made another operation necessary.

During cross-examination on his qualification as an expert witness, the physician called by the patient stated that he knew nothing of the standards, procedures, and techniques of osteopaths. On redirect examination, he was asked if he was familiar with the standards of osteopaths in performing oophorectomies. The osteopath's objection to the question, based on the physician's prior admission that he was unfamiliar with osteopathic standards, was sustained. An offer of proof was made that the physician would have testified that the standards for performing oophorectomies were the same for physicians and osteopaths. Since the physician had stated, without qualification, on cross-examination that he was unfamiliar with

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osteopathic standards, he could not be permitted on redirect examination to contradict that testimony, even in part, in the face of the osteopath's timely objection. Thus, the sustaining of the objection was not reversible error.

However, the appellate court was incorrect in stating that the general rule prohibits opinion testimony from a medical practitioner solely because he is not a practitioner of the same school of medicine as the practitioner whose standards of practice are in issue. The Supreme Court said that, although there was language in some cases which suggested that such was the rule, it had never directly decided the specific question. The proper rule is that the standard of exclusion is not the school of the witness but his knowledge of the standards of the practitioner whose standards are in issue. In malpractice cases, the opinion testimony of a witness knowledgeable on the standards applicable to the profession of the practitioner against whom suit is brought and his compliance or noncompliance with those standards, is admissible, even though the witness does not practice the same profession or belong to the same school of healing as the practitioner against whom suit is brought.

In view of the physician's express disclaimer of knowledge of osteopathic standards, his testimony was not admissible under the "exception" referred to by the patient, which permits a witness of a school of medicine different from that of the practitioner against whom suit is brought to testify as to matters on which the principles of the two schools concur. — *Frazier* v. *Hurd*, 157 N.W.2d 249 (Mich., April 1, 1968) ☐

(Editor's Note: The decision of the appellate court was reported in THE CITATION, Vol. 15, No. 4, p. 58.)

USPHS TO STUDY HEALTH OF KENT COUNTY TEEN-AGERS

The U.S. Public Health Service will examine 200 Kent County young people, ages 12-17, during a three-week period beginning August 21, as part of a nationwide survey to ascertain the health of American teen-agers.

The health examinations, which will be conducted in the Survey's mobile center, are designed to collect data primarily on the health aspects of growth and development. The Survey is not intended as a screening procedure; referral for diagnosis is not made.

Parents of each youth examined are told that the examination is neither complete nor can be looked upon as a substitute for a visit to one's own physician and dentist, the Public Health Service explains. ☐

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Why MDPAC-AMPAC? What's It All About?

BY VERNON V. BASS, M.D.
CHAIRMAN, MDPAC
SAGINAW

Making laws is one of this nation's major activities. It keeps Congress busy for nearly eleven months out of twelve these days. Fifty state legislatures add thousands of laws more each year. Cities contribute a flood of ordinances to the total. The regulatory agencies crank out regulations in awesome numbers.

With the effect this entire process has on a business, an industry, a profession, a group of people, or the individual taxpaying citizen who must conform to the rulings of the legislative majority, it would seem logical to expect breathless attention to all these goings-on from every person of voting age in the United States. But as all of us know, it doesn't work out that way. Not one person in five is a political activist in the sense that he works for the political party of his choice, supports it financially to the degree that he is able, or turns a hand to the necessary work of helping a candidate win.

Until recent years, business, industry and the professions limited their activities to lobbying for specific legislative proposals.

THIS ATTITUDE IS CHANGING. Clearly, a loner in politics accomplishes little more than the casting of his single vote, important though that is. Just as clearly, a group of like-minded individuals can multiply their political effectiveness. Nothing prevents separate political groups like MDPAC from forming, on the basis of a shared point of view, and then working for a particular candidate as an auxiliary to his party organization during a three or four month campaign.

The new look in candidate support committees is different. They now function as parts of a permanent organization tied to neither party.

They are candidate oriented, but work for a selected candidate only during his campaign. They then sever the relationship until the next time the office is being contested and may, if they chose, decide at that time based upon the candidate's record, to support someone else.

These political hybrids are the new political action committees, of which MDPAC is one, and they are not only here to stay but constitute a force of growing power.

AUTONOMOUS POLITICAL action committees are now operating in each of the fifty states as well as in the District of Columbia, with members belonging to their State PAC and AMPAC as well.

Candidates are chosen by PAC members at the local level on the basis of political principles, chance to win, need for help, and several other factors. The PAC members within a Congressional District then set out to form a candidate support committee, raise money, and provide volunteer services for the candidate they choose.

If additional financial help is needed, the district candidate support committee applies to the State PAC. Political realism governs that decision.

Recognizing that able, intelligent candidates are to be found within the ranks of both political parties, MDPAC and AMPAC are resolutely bipartisan.

AMPAC is involved primarily in races for the

House, but has worked effectively in campaigns for the U.S. Senate.

The Michigan Doctors Political Action Committee is oriented to key congressional contests, but also involves itself in campaigns for the state legislators as well as other selected educational and judicial posts.

The American Medical Political Action Committee (AMPAC) was formed with the American Medical Association's official blessing as a voluntary, non-profit, unincorporated organization whose purpose was to help its members participate effectively in public affairs; further their political knowledge; and develop the means for concerted political knowledge; and develop the means for concerted political action.

AT THE NATIONAL LEVEL, AMPAC seeks to provide coordination, liaison and political training for its members. In terms of this training, a variety of political education programs is made available for use by MDPAC members. Courses in precinct action, films on politics, pamphlets on how to form political opinion, a membership periodical, exhibits are some of the materials AMPAC produces and disseminates. In essence, this sort of political education is comparable to the programming done by many of the public affairs departments of the nation's large corporations.

DOES THIS OVER-ALL approach work?

It does indeed.

AMPAC is now second only to labor in the total of its dollar support to Congressional candidates. And AMPAC's files are filled with testimonials from political candidates who believe that the margin between their defeat and victory at the polls was provided by the combined effort of physicians and their wives.

In these troubled days when Congress is called upon to consider a plethora of bills involving the nation's health medicine clearly has a gigantic stake in the election of intelligent men and women who will at least listen to the point of view of medical authorities before they make up their minds on proposed health legislation.

Medicine's PAC movement both at the national and state levels is helping to assure the election and re-election of such people, recognizing that legislative arguments minus candidate support often equal futility squared.

The MDPAC board is currently assessing the voting record of all legislators and will financially support on a bipartisan basis over fifty candidates for the 1969 legislature. Several members of the Michigan delegation to the Congress have likewise been recipients of MDPAC funds. Much more help is needed particularly by candidate support committees. MDPAC has doubled its membership in 1967. It is now approaching 30% of MSMS membership. This is due in part to billing procedures used in all counties except Wayne County.

MDPAC's EFFECTIVENESS could develop into a brilliant political success story. It needs your help to accomplish this, and in the 1968 election year a membership of at least a third of Michigan doctors is essential.

For twenty-five dollars ($25.00) become a member of both AMPAC and MDPAC. Mail your check to MDPAC, Box 169, East Lansing, Michigan 48823. Join the team! □

MSMS CONTINUES PAP TEST APPEAL

Daily and weekly newspapers throughout Michigan continued to carry the appeal of the MSMS Cancer Committee to Michigan women to have Pap tests.

Some of the headlines on the MSMS news release read:

Union Lake Spinal Column: "Cancer Check-ups Save Lives."

Detroit West Side Courier: "Urge Women Have Cancer 'Pap' Test."

Lansing State Journal: "Annual 'Pap' Test Needed."

Holly Herald-Advertiser: "Urge Women to Take 'Pap' Test."

Belleville Enterprise-Roman: "Physicians Advise Yearly 'Pap' Test to Spot Cancer."

Trenton Times: "Doctors Call Lack of 'Pap' Tests 'Tragic'."

TELLS GRADUATES EXPAND HORIZONS

Austin Smith, M.D., chairman of the board of Parke, Davis & Company, recently challenged the graduating seniors of the Massachusetts College of Pharmacy and Science to play a greater individual role in modern society.

Doctor Smith, who also received the college's 31st honorary degree, a "Doctor of Science in Pharmacy," urged students to expand their professional and personal horizons following graduation. "The greatest profession of all lies before you — the profession of living," he said. "The need to grow, to expand one's horizons, to realize that we cannot, as a professional person, or as a private individual, live in an isolated world, oblivious to outside influence or change.

IN MEMORIAM

F. J. Fitzpatrick, M.D., Pontiac

Francis J. Fitzpatrick, M.D., Pontiac internist for 41 years, died May 22. He was 70.

Doctor Fitzpatrick was a Life Member of MSMS and an honorary member of the staff at St. Joseph Mercy Hospital, Pontiac. He was graduated from the University of Michigan Medical School in 1924. He was a Diplomate of the Board of Internal Medicine and a member of Nu Sigma Nu medical fraternity.

W. E. McGillicuddy, M.D., Dearborn

Walter E. McGillicuddy, M.D., retired Dearborn otolaryngologist, died April 5 at the age of 86.

Doctor McGillicuddy, a 1913 graduate of the Detroit College of Medicine and Surgery, practiced pharmacy in Ontario and Detroit for a number of years. During World War I he served in the U.S. Army in France as an anesthetist. He formerly was on the staff of the Detroit Eye, Ear, Nose and Throat Hospital for eight years and was also affiliated with the Detroit T.B. Sanitarium.

He was an active member of the Masons and traveled extensively, visiting various hospitals in the interest of welfare work for Masonic organization. His hobbies were fishing and hunting and he was a member of the Paul Bunyon Conservation Club, French River Fishing Club, Canada Bon Ami Hunting Club and the Harmonie Society of the Canada Creek Ranch Association.

F. T. Reid, M.D., Birmingham

Fred T. Reid, M.D., Birmingham, died June 12 at the age of 71. Doctor Reid had practiced in the Detroit area since he received the M.D. degree from the University of Michigan Medical School in 1923.

His internship was at Grace Hospital, and he was a member of staff at Grace Hospital, St. Joseph's Mercy Hospital in Pontiac, and Ardmore Hospital in Ferndale. He served as a health officer at Clawson and received a 25-year service award as a Selective Service examiner.

He was a Life Member of MSMS, and had been a member of the Board of Directors of the Oakland County Medical Society.

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M. N. Southworth, M.D., Kalamazoo

Maynard N. Southworth, M.D., Kalamazoo general practitioner, died June 10 at the age of 62.

Doctor Southworth received the M.D. degree from the University of Michigan Medical School in 1930. He was affiliated with Borgess and Bronson hospitals in Kalamazoo and had served as a township health officer. From 1942 to 1946 he served in the Medical Corps. He was a member of the American Legion, the Elks Club and Theta Kappa Psi medical fraternity.

H. A. Sullivan, M.D., Detroit

Hugh A. Sullivan, M.D., surgeon at Harper Hospital, Detroit, for over 50 years, died June 1. He was 75.

Before his retirement, he was chief surgeon for the Department of Streets and Railways of Detroit for 42 years. He also served as a surgeon for the Detroit Police Department for 30 years.

He received his medical education at the Detroit College of Medicine, graduating in 1915. During World War I, he served on a surgical team headed by neuro-surgeon Harvey Cushing and later with Harper Hospital Base #17 in France.

Doctor Sullivan was a founding member of the American Board of Surgery and was a past president of the Detroit Academy of Surgery in 1942. He was a Life Member of MSMS and a member of the American College of Surgery and Phi Beta Pi.

G. C. Tornberg, M.D., Cadillac

Gordon C. Tornberg, M.D., Cadillac physician, died May 26 at the age of 55.

He had served as president and secretary of the Wexford-Missaukee County Medical Society and was an examiner for the Selective Service Board for 15 years. Active in community affairs, he was a member of the Chamber of Commerce, Rotary Club and Cadillac Club.

Doctor Tornberg practiced in Cadillac from 1940 until several years ago. He was a 1939 graduate of the University of Minnesota Medical School and also held a B.S. degree from the University of Michigan. His internship was served at St. Mary's Hospital, Duluth, Minnesota.

HPCM MOVES

The Health Planning Council of Michigan has moved from its present offices at 414 Hollister Building, Lansing to new quarters at 2213 East Grand River, Lansing, Michigan 48912. The telephone number, 482-5529, remains unchanged.

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Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
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Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.

* 1904 - 1967

A model of the Grand Rapids Public Museum area which will house a major new medical and health display is explained by Weldon D. Frankforter, right, museum director, to Charles Farber, M.D., left, president of the Kent County Medical Society; Frederick Brace, M.D., second from left, and James Muldoon, M.D., third from left.

Kent Doctors Provide Museum Health Display

A display of transparent human figures, fitted with tape-recorded "voices," will soon become a central part of a new major display at the Grand Rapids Public Museum thanks to a $25,000 grant from the Kent County Medical Society.

A complete "growth and development" series of displays will also be included to show the process of conception and birth.

"This will be a permanent medical exhibit showing the physical development of man," said Charles Farber, M.D., president of Kent County Medical Society. "We, the physicians of Grand Rapids, are taking the initial step in establishment of this exhibit, and it is our hope that the exhibit will be enlarged and extended to eventually include all fields of health."

Planning for the display, which will be a reality by the fall of 1969, has been done by a special committee of the Medical Society, headed by James Muldoon, M.D., of Grand Rapids and working closely with Weldon D. Frankforter, Museum Director. Also active on the committee is Fred Brace, M.D., of Grand Rapids. ☐

Parke, Davis Adds New Jersey Firm

Parke, Davis & Company has purchased the assets of the PanAura Corporation, of Pennsauken, N.J., a subsidiary of Kewanee Oil Company. The PanAura included the prototypes of several medical electronic products, patents, inventions, and electronic laboratory equipment. ☐

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles o face may be minimized by withholding dieta salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued wit the appearance of edema. The drug has bee associated with peptic ulcer and may reacti-

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vate a latent peptic ulcer. The patient should e instructed to take doses immediately after neals or with milk to minimize gastric upset. rug rash occasionally occurs. If it does, romptly discontinue the drug. Agranulocyosis, exfoliative dermatitis, Stevens-Johnson yndrome, Lyell's syndrome (toxic necrotizng epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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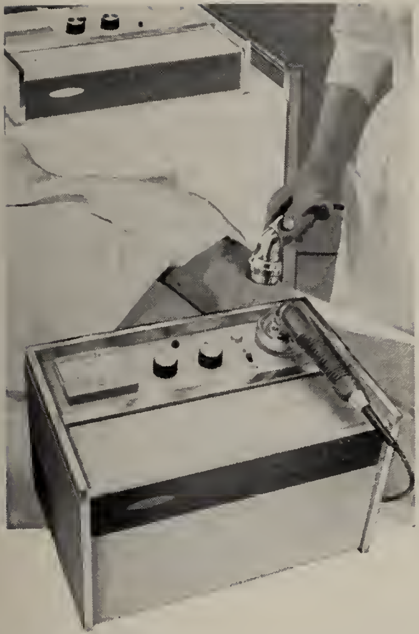

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MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Michigan State Medical Society

Edward F. Knoschnabel, M.D., Marquette,
is aboard the S.S. Hope on its second rotation in Ceylon from June 13 through August 15. He is the only otolarngologist on the staff.

Joseph A. Witter, M.D., Highland Park,
was honored by the medical staff of the Highland Park General Hospital at the annual dinner for his activities as chief of surgery at the Highland Park hospital from 1956 to 1968.

Michael S. Leahy, M.D., Ann Arbor,
has been selected the outstanding resident of the year at the University Hospital. For his outstanding work as the senior resident in pathology, he will receive an honorarium and a certificate of achievement.

Paul T. Lahti, M.D., Royal Oak,
and his associates were pleased to find in a recent article in *Time* quotations from Doctor Lahti's article "Early Postoperative Discharge of Patients from the Hospital," published in *Surgery,* March 1968.

David Hills, M.D., St. Joseph,
has been named to head a committee to unify health planning in the St. Joseph-Benton Harbor area on a long-range basis.

Frederick J. Chapin, M.D., Bay City,
immediate past president of the Bay, Arenac, Iosco Counties Medical Society, surprised members of the county society with his announcement that he would be leaving the pediatrics practice he has had there for 23 years. He will train in and practice psychiatry in Traverse City.

Michael J. Brennan, M.D., Detroit,
has been named to the National Advisory Council on Regional Medical Programs of the National Institutes of Health. The Advisory Council assists in policy matters and in the preparation of regulations and also makes recommendations on grants.

Louis Carbone, M.D., Detroit,
was saluted as a "physician to mankind, friend to St. John Hospital and contributor to his community" when he received the "Man of the Year" award of St. John Hospital, Detroit.

William H. Beierwaltes, M.D., Ann Arbor,
told the Society for Nuclear Medicine recently in St. Louis that three cancer patients at the U-M Hospital have received a new diagnostic drug which apparently has revealed the extent of malignant melanotic tumors for the first time. The drug, NM-113, he said, is structured like chloroquine and contains a radioactive atom which quickly reveals its presence to photo-scanning instruments.

Harold F. Raynor, M.D., Detroit,
recently received a Golden Anniversary Diploma from the WSU Alumni Association in recognition of his 50 years in medicine. Although retired from private practice since 1957, Dr. Raynor continues to work as associate medical director at the American Red Cross, Elizabeth Street, Detroit, and as a physician for the Highland Park Fire Department.

Sol C. Grossman, M.D., Huntington Woods,
has been elected president of the Michigan Psychoanalytic Society for 1968-69. Other officers chosen are: vice-president, Saul Harrison, M.D.; secretary, Ira Miller, M.D., Ann Arbor; treasurer, Jack Dorman, M.D., Detroit.

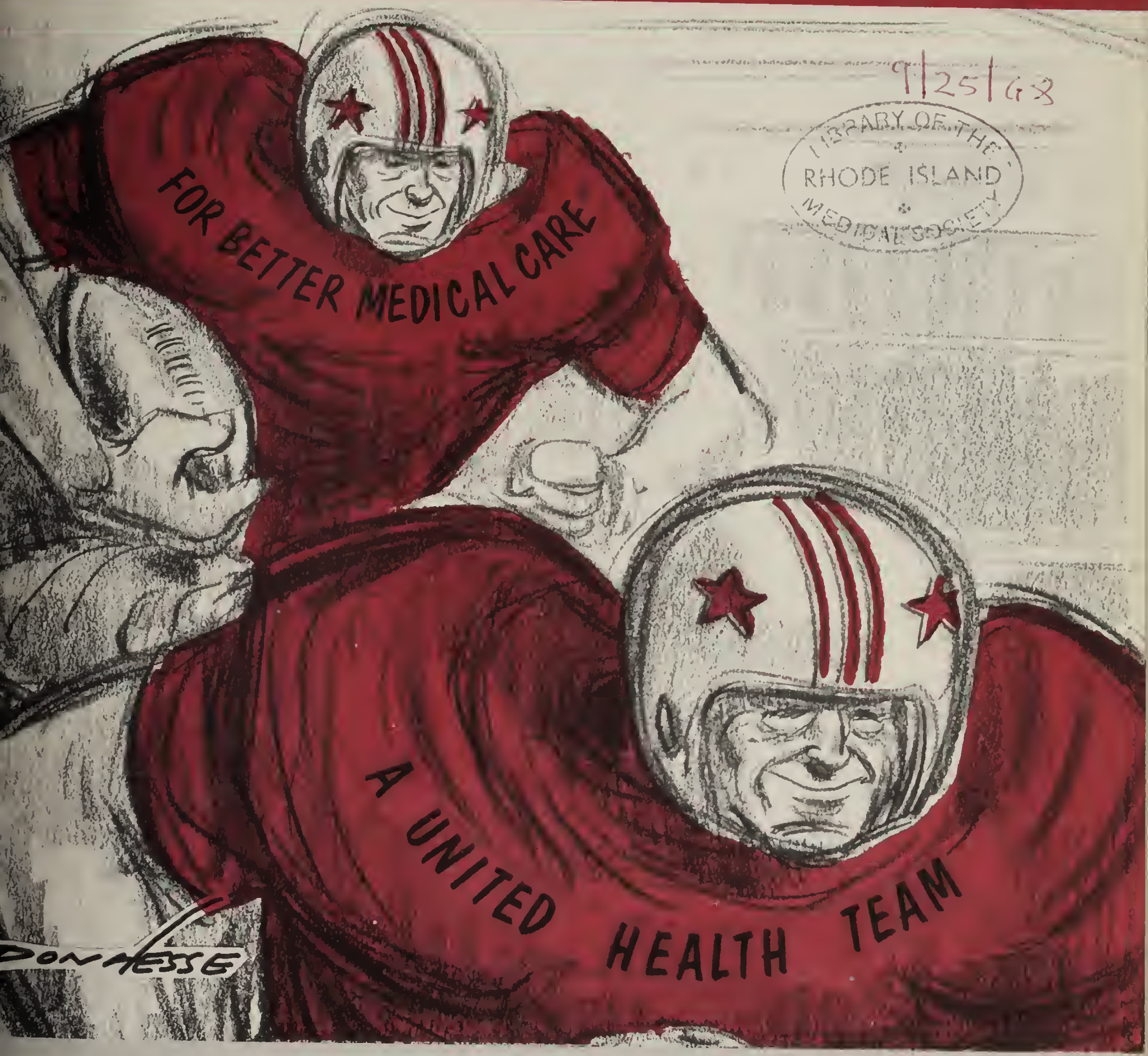
Paul L. Lowinger, M.D., Detroit,
spoke at Oxford, England, at the meeting of the Medical Association for Prevention of War. His topic was "Hospitals, Doctors, and Riots."

Fred W. Whitehouse, M.D., Detroit,
is the newly-elected president of the Michigan Diabetes Association. He is Chief of the Metabolism Department of Henry Ford Hospital, Detroit.

Samuel J. Nichamin, M.D., Southfield,
is the author of an article "Atypical Manifestations of the Recurrent Pleurodynia Syndrome in Children and Adolescents" in the April 1968 issue of *Clinical Pediatrics.*

Frederick C. Swartz, M.D., Lansing,
chairman of the AMA Committee on Aging, was a featured speaker at a special half-day session on automated multiphasic screening programs during the recent AMA Annual Convention in San Francisco.

MICHIGAN MEDICINE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VOLUME 67, NUMBER 17
SEPTEMBER 1968

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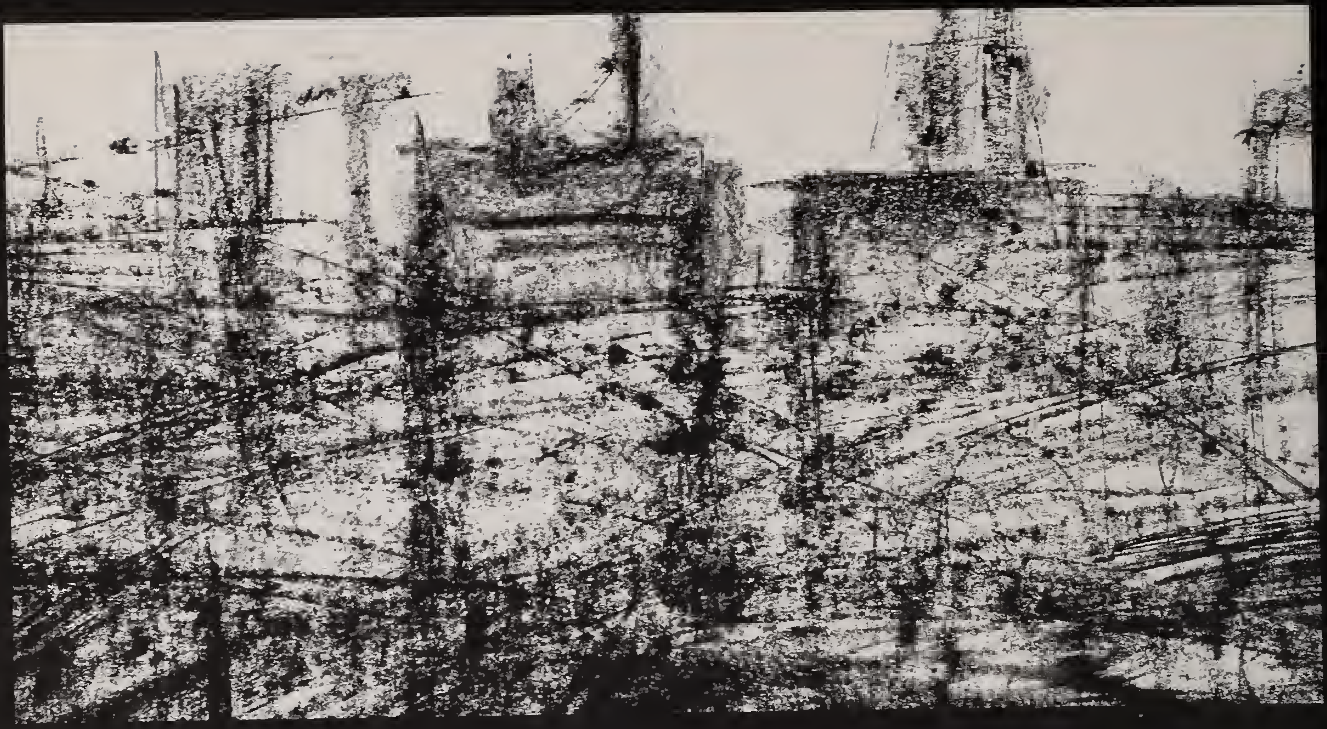
Sept. 22-24 — MSMS House of Delegates
Sept. 25-26 — MSMS Annual Scientific Session
Sept. 24-26 — Woman's Auxiliary to MSMS
Sept. 25-26 — Michigan State Medical Assistants Society
Sept. 22-Oct. 20 — "Ars Medica Art Exhibit"



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- MDPAC Breakfast
- Office Management Seminar
- MSMS Party
- "Ars Medica Art Exhibit"
- Educational Exhibits
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SEPTEMBER, 1968 • VOLUME 67 • NUMBER 17

SCIENTIFIC ARTICLES

1061 Power Motor Injuries of the Hand; J. Joseph Danyo, M.D., Kim K. Lie, M.D., Robert D. Larsen, M.D., Joseph L. Posch, M.D.

1063 Evaluation of a Screening-Technique for Urinary Tract Infections In Diabetic Out-Patients; Ali Abbasi, M.D., Lawrence Power, M.D.

1066 The Treatment of Trigeminal Neuralgia And Other Facial Pain with Carbamazepine; K. I. Kiluk, M.D., R. S. Knighton, M.D., J. D. Newman, M.D.

1070 Acute Myocardial Infarction Preceding Diabetes Mellitus; Marjorie Peebles-Meyers, M.D.

1071 Faulty Neurologic Integration With Perceptual Disorders in Children: An Abridged Treatment Approach; A Two-Dimensional Program of Methylphenidate and Psychologic Management; Samuel J. Nichamin, M.D., George D. Barahal, Ph.D.

1076 Marked Eosinophilic Response to Combined Chlorpromazine and Trifluoperazine Therapy; Melvin J. Reinhart, M.D., Martha Stephens, M.D.

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THE COVER

This month the cover recognizes the beginning of football season to call attention to the need for teamwork during the 1968 Community Health Week in October. The cover cartoon was made available by the AMA Communications Department. See Page 1083 for CHW details.

OFFICIAL PUBLICATION • MICHIGAN STATE MEDICAL SOCIETY

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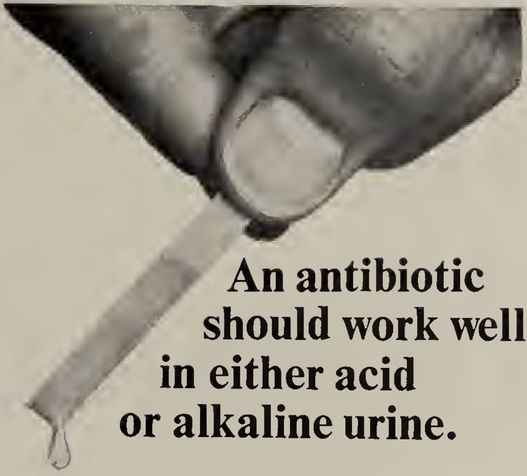

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system — anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin — maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney — rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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A recent editorial in JAMA discussed the continuing education efforts of state medical societies and declared that such programming, "demonstrates the leadership in maintaining professional competency can be assumed by the profession itself . . . and that is exactly where it belongs."

1968 MSMS Annual Session
September 25-26, 1968
Sheraton-Cadillac Hotel
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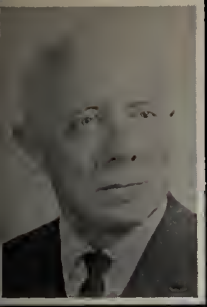


BY BRADLEY M. HARRIS, M.D.

MSMS PRESIDENT'S MESSAGE

Thank you . . .

With deep gratitude, I want to thank you for the opportunity to serve as President of this outstanding Michigan State Medical Society this past year.

Many of our major efforts this year will be continued effectively this coming year by MSMS under the excellent leadership of Jim Lightbody.

Considerable time and effort has been spent during 1967-1968 in the areas of continuing education, legislation, federal medical programs, medical manpower, and communications. In its more than 100 years of service to the public and the medical profession, MSMS has a fine record of performance in this complex field and many others. The House of Delegates, The Council, and our committees have acted wisely to establish realistic policies and to implement vital programs. New guidelines, I am sure, will be considered this month by the 1968 House of Delegates.

The State Society, the county medical societies, and every physician must become better informed about the many federal medical programs. These will continue to demand our attention so the medical profession can help them work effectively and economically to serve those who may need special medical services.

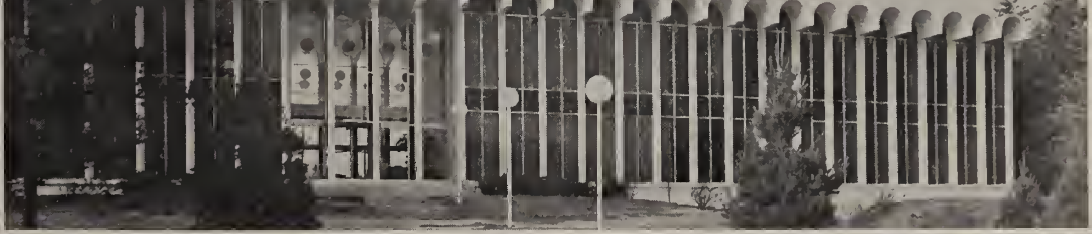
Medical legislation is closely related to the federal programming and I am pleased to see more and more county medical societies improving liaison with their state legislators and national congressmen. MDPAC has made tremendous strides forward this past year.

It seems hardly necessary to challenge each physician to become even more concerned about good communications, strong medical career recruitment efforts, and meaningful postgraduate educational projects. In all these fields, MSMS has strong committees providing solid direction — and staff members that are skilled, creative, and energetic. MSMS has a very good staff of dedicated men and women, and I offer my sincere thank you to each of them for guidance and encouragement given to me this past year.

MSMS has gained considerable stature during the past several years at the meetings of the AMA House of Delegates. Michigan delegates continue to offer timely resolutions, to serve effectively on various reference committees, and to debate the issues with statesmanship.

As a MSMS representative this year, I was well received at meetings of county medical societies, nearby state medical societies, the Upper Peninsula Medical association, AMA functions, and activities of many medical and health-related organizations.

I pledge my support to future MSMS leaders so together we can build an even more effective state medical society to serve the public and the medical profession.



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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietar salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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g rash occasionally occurs. If it does,
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tion similar to a serum sickness syn-
me may occur and require permanent
drawal of medication. Agranulocytosis
occur suddenly in spite of regular, re-
ted normal white counts. Stomatitis, sali-
gland enlargement, vomiting, vertigo and
uor may occur. Leukemia and leukemoid
tions have been reported. While not defi-
ly attributable to the drug, a causal rela-
ship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests The system can be used to measure hemoglobin, glucose, cholestero urea nitrogen, total bilirubin and uric acid. Write today for full details.

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et's be specific about Campbell's Soups…
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

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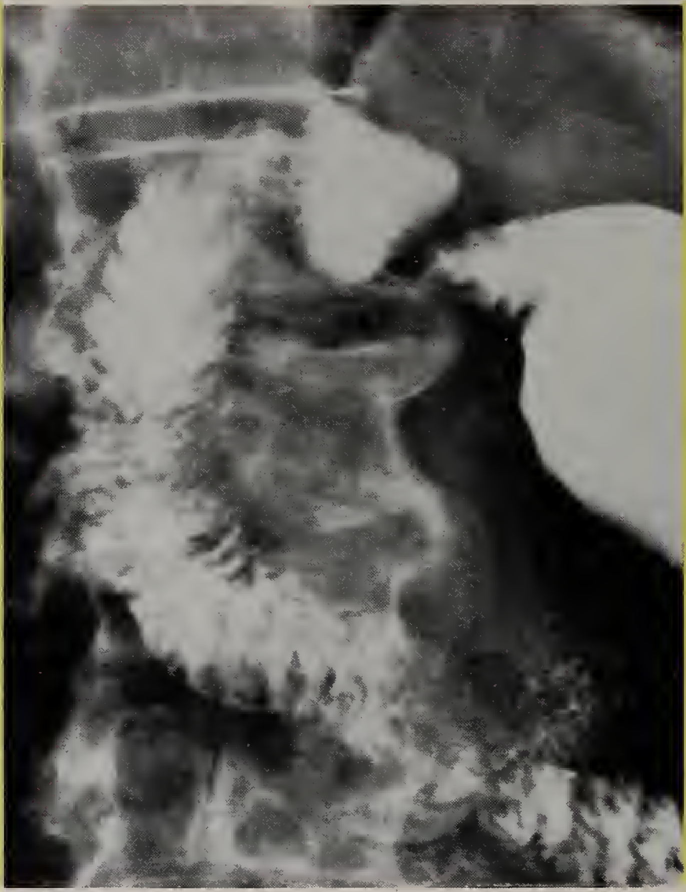
Campbell's
CONDENSED
SOUP

THE RESTLESS DUODENUM...



DUODENUM—(Conventional X-ray) The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive. Is this duodenum normal?

Pro-Banthīne®

brand of
propantheline bromide

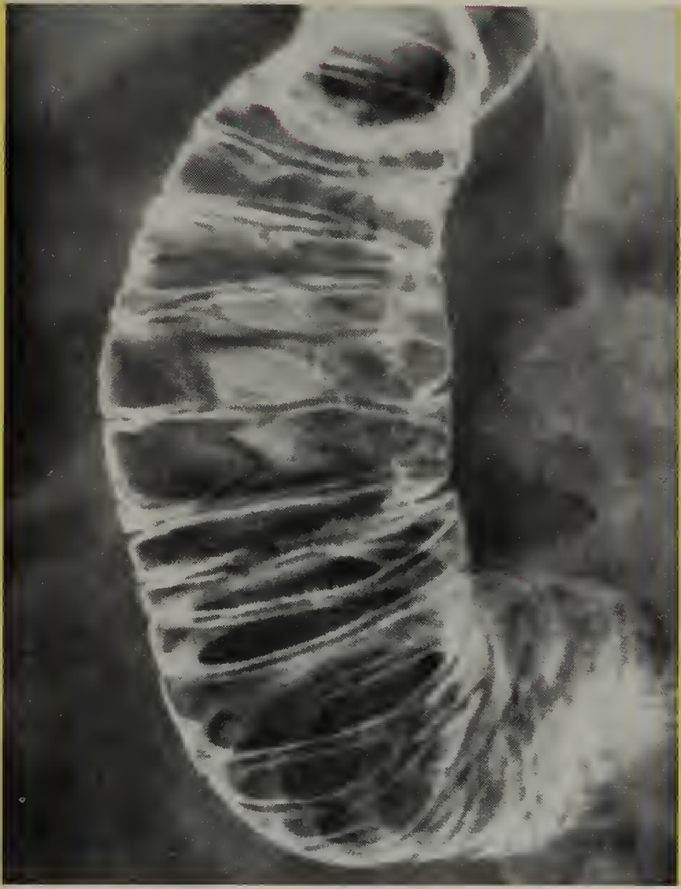
For fifteen years Pro-Banthīne has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthīne has reestablished its pharmacologic effectiveness in facilitating diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal trac was relaxed with Pro-Banthīne. The duo denum was intubated. Pro-Banthīne i a dose of 60 mg. intramuscularly wa used to assure prompt aperistalsis, an double-contrast visualization wa achieved with ordinary barium and ai

The same pharmacologic efficienc has proved of pronounced value in suc conditions as: *peptic ulcer, pylorospasm biliary dyskinesia, functional hyperm tility and irritable colon.*

...AT REST



SAME DUODENUM—(Hypotonic X-ray) Pro-Banthīne-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

ontraindications: Glaucoma; severe cardiac disease.
recautions: Since varying degrees of urinary hesi-
ıncy may occur in elderly males with prostatic
ypertrophy, this should be watched for in such
atients until they have gained some experience
ith the drug. Although never reported, theoreti-
ally a curare-like action may occur with possible
ss of voluntary muscle control. Such patients
hould receive prompt and continuing artificial res-
ration until the drug effect has been exhausted.
de Effects: The more common side effects, in or-
er of incidence, are xerostomia, mydriasis, hesi-
ıncy of urination and gastric fullness.
osage: The maximal tolerated dosage is usually
e most effective. For most *adult* patients this will
four to six 15-mg. tablets daily in divided doses.
severe conditions as many as two tablets four to
x times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology 89:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. 50:445-460 (May-June) 1955.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

LeRoi J. Alexander, M.D., 5003 N. Saginaw Street, Flint, 48505

Carlos J. Bulcourf, M.D., 31170 Hoover Road, Warren, 48093

Manuel M. Campos, M.D., 72 Sheldon Ave., S.E., Grand Rapids, 49502

Allen J. Enelow, M.D., 936 Southlawn, East Lansing, 48823

John Christian Gall, M.D., Simpson Memorial Institute, Ann Arbor, 48104

Mark P. Harmeling, M.D., 500 Cherry St., S.E., Grand Rapids, 49503

Mary Herlihy, M.D., 101 Marcy, St. Charles, 48655

Helen E. P. Lanting, M.D., St. Joseph River Valley, Mental Health Clinic, 2002 State Street, St. Joseph, 49085

Charles G. Mendelson, M.D., Henry Ford Hospital, Detroit, 48202

Benjamin A. Passos, M.D., 304 N. Cochran Ave., Charlotte, 48813

Om Prakash, M.D., 1023 William Street, Lansing, 48915

Gerard Scott, M.D., 5670 Dixie Highway, Saginaw, 48601

James P. Sheehy, M.D., 503 S. Saginaw Street, Flint, 48502

Thomas E. Stone, M.D., 6520 Fairfield, Garden City, 48135

Robert D. Gibson, M.D., 804 Newberry Ave., Newberry, 49868

Donald A. Meier, M.D., 20905 Greenfield Road, Southfield, 48075

Glen L. Byers, M.D., Detroit General Hospital, Detroit, 48226

James M. Holbrook, M.D., 3509 Meckl Drive, Warren, 48092

* Office Management Seminar

THURSDAY AFTERNOON, SEPTEMBER 26, 1968
SHERATON CADILLAC HOTEL, DETROIT

During 1968 Annual Scientific Session Of the Michigan State Medical Society

. . . especially prepared for newly-practicing physicians, residents, interns, and senior medical students.

. . . a special educational program of the Michigan State Medical Society

A series of lectures and discussions about:

"How to Set Up and Run an Efficient Office"
"How to Hire and Train Employees"
"To Solo or Not to Solo"
"What Shall I Do with the Money I Earn"
"A New Billing and Collection Plan"

September 26, 1968 from 3 to 5 p.m.
English Room, Sheraton-Cadillac Hotel, Detroit

* *Made possible by a grant from Merck Sharp and Dohme Postgraduate Program.*

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For Iron Deficiency Anemia

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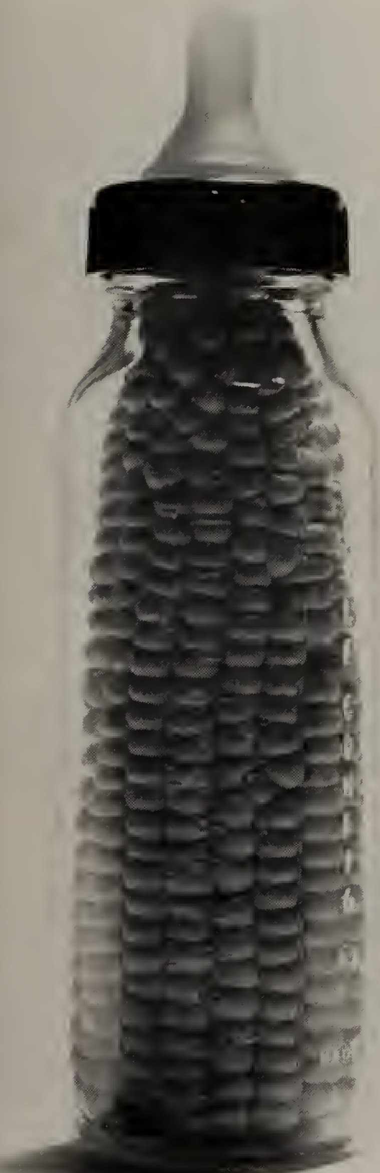
HOW CORNY SHOULD A FORMULA BE?



Just enough to eliminate unnecessary ingredients and provide excellent nutritive value. Both corn oil and corn syrup solids are used in Modilac™ Gerber Baby Formula to provide essential nutrients with allergenic potential from only a single additional protein source. Corn oil replaces butter fats, supplying generous levels of the essential linoleic acid. Corn syrup solids provide dextrose, maltose and dextrins for spaced carbohydrate absorption. All of these components come from the single ingredient—corn, thus minimizing the possibility of allergy arising from a variety of ingredients.

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Why is corn oil used? Because it is high in linoleic acid which presumably lowers serum cholesterol, provides for greater caloric efficiency[1] and is necessary for maintaining skin integrity.[2]

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Why is Gerber Modilac, with its corn derived ingredients, a formula of choice? Because clinical tests[3,4] have shown it to have a high caloric and protein efficiency. Babies using it show excellent growth rate, low serum cholesterol, normal stooling and a low incidence of diaper rash or skin irritation.[3]

[1] J. Nutrition 66:555-565, 1958.
[2] Acta Paediatrica, Suppl. 137, 1962.
[3] Jrl. of Pediatrics 64:666-682, 1964
[4] Pediat. Clinic N. Amer. 12:309-335, 1965.

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VIEWPOINTS

House Reference Hearings Are Open

BY JAMES B. BLODGETT, M.D.
MSMS SPEAKER

The September meeting of the MSMS House of Delegates is the first regular meeting at which I shall preside as your newly-elected Speaker. I am grateful for this honor and mindful of the responsibility that this privilege implies.

The Annual Meeting of the elected Delegates is the means by which MSMS policy is determined and implemented. Each seated Delegate represents 50 physicians from his district.

IT IS THE BUSINESS of the House to consider committee actions and recommendations from the previous year and act upon resolutions which are presented to it by its members. These matters are first referred to Delegates Reference Committees composed of a number of Delegates. At the hearing of these committees the questions are studied in depth by consideration of pertinent data and by discussion with interested Delegates and members.

> *The reference committee meetings are held at a time when the House is not meeting and are open to any interested persons. The recommendations of the Reference Committees are then reported to the House where they are further discussed and considered by the full membership. Only then is action taken which may approve, disapprove or study further the questions at hand.*

In addition to these deliberations, the House directs policy through its various elections. The House elects Delegates to the National House of Delegates of the AMA; members of The MSMS Council who provide the continued direction of MSMS between sessions of the House; physician representatives on the Board of Blue Shield; members of the Judicial Commission; and finally the officers of the State Society including the Speaker.

IT IS IN THIS manner that your Delegates exercise a direction of the Society in making policy and its implementation. As Speaker, it is my duty to see that this democratic process is fairly and efficiently carried out to implement the rule of the majority and to protect the rights of the minority and the individual Delegate.

I am aware, as you are, that ideas arise from individuals, they are tested by discussion and reference to the facts and then they are implemented by the judgement of the majority.

> *In the interest of efficiency and equity we will request that resolutions be submitted early enough before the meeting of the House that they can be in the hands of the Delegates at the time of the meeting. We will recommend that no new resolutions be introduced after the second session so that adequate consideration can be afforded them by the reference committees.*

DURING THE FINAL session of the House the delegates selected by all of the county medical societies will elect the officers and councilors who will make a significant contribution of their time, and effort, in conducting the affairs of the Society. The offices to be filled by these elections are of great importance and it will be your Delegates' responsibility to select men you want and trust, and men who will properly represent you. Each election should and will receive the most careful consideration.

All members of MSMS are cordially invited to observe the deliberations of the House and to take part in the meetings of the reference committees. □

MSMS Annual Session Helps Assure Competency

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

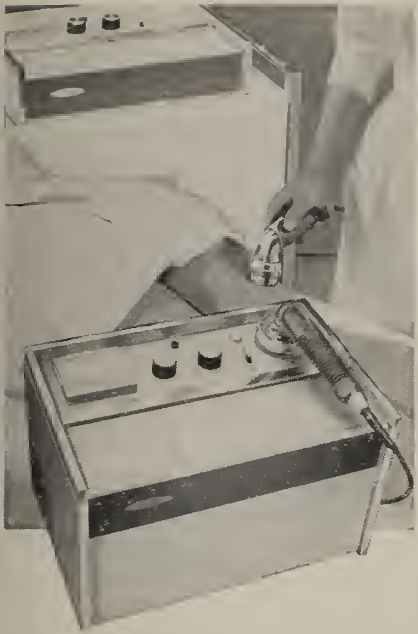
Graduate—"One who has received a degree or diploma on completing a course of study" (The American College Dictionary).

It is unfortunate that the dictionary utilizes the word completing. Graduation from medical school should be looked upon as the start of one's course of study rather than the completion.

Most graduates of medical school today will embark upon as many years of formalized training as they spent in medical school . . . and they will still not be a graduate by the above definition.

It is impossible (if one is to be a competent physician) to ever complete the course of study

(Continued on page 1036)



Another step forward in Ultrasonics The Burdick UT/420 Continuous or Pulsed Ultrasound

Burdick introduces its newly designed UT/420 Ultrasound! Handsomely styled, the new UT/420 produces a combination of thermal, mechanical, and chemical effects in tissue not possible with any other modality. Selection of continuous or pulsed energy offers flexibility of treatment—pulsed ultrasound permits increased mechanical effects at higher intensities without pain.

Ask your Burdick dealer about the UT/420 (he has an Ultrasound Dosage Chart for you as an aid to more effective treatment)—or write us.

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The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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in medical education — as it is a continual ongoing process.

The changes in technology, methodology, and pharmacology make the Buck Rogers' stories of our youth pale by comparison. Medical societies, hospitals, professional groups and medical schools have embarked upon massive programs in continuing medical education to keep physicians well informed and up-dated.

The MSMS Annual Scientific Session at the Sheraton-Cadillac Hotel in Detroit, September 25-26, is but one effort by your Society in continuing medical education. Four post-graduate day-long courses will be held by eminent authorities embracing "Infectious Diseases," "Pulmonary Diseases," "Blood Diseases" and "Difficult Decision in Digestive Diseases." These are in addition to scientific exhibits, general sessions and specialty group discussions.

It is hoped that the members of MSMS will find the scientific session of the annual meeting rewarding and informative.

Medicare No Panacea

BY BROOKER L. MASTERS, M.D.
MSMS COUNCILOR

How has the public reacted to Medicare and proposals to expand it for those under 65?

There have been several surveys conducted by reputable organizations in recent months.

Many of our patients are referring now to a survey conducted by *Better Homes and Gardens* magazine. The study was conducted in cooperation with Opinion Research Corporation of Princeton. A total of 278,477 completed questionnaires, printed in the October and November, 1967, issues.

Better Homes and Gardens reports now that:

"Medicare evidently is not a panacea in the minds of the respondents. A strong 8 in 10 indicate an unwillingness to finance Medicare for those under 65 through additional Social Security taxes. In fact, 18 percent feel that Medicare should be done away with entirely (13 percent of the respondents feel that Medicare should be available to all.)"

There were other questions about medicine in the questionnaire. Let me quote the magazine again.

"Two-thirds of the respondents feel doctors' fees are high but justified by greater training and skill, in line with other professionals, and are quite fair."

For years many physicians have argued that Medicare was unwise and costly. Despite these views, the physicians have cooperated to make Medicare work as effectively as possible.

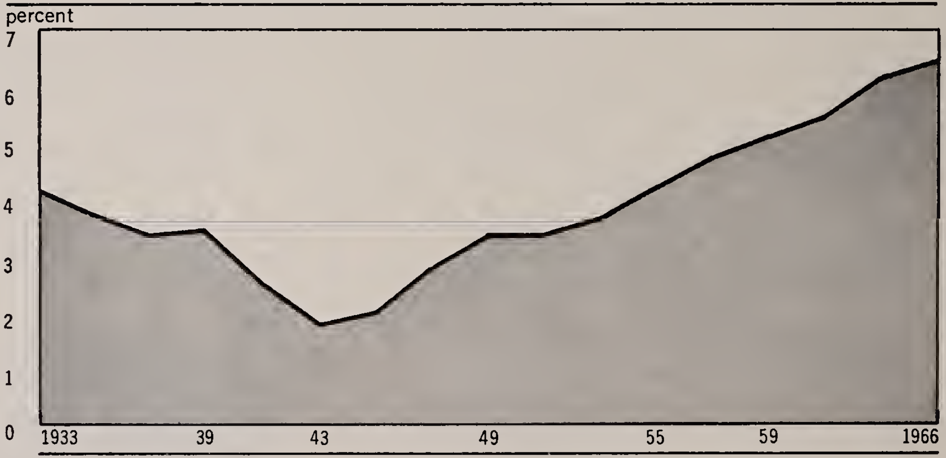
The *Better Homes and Gardens* magazine reveals to all of us that quite a few citizens, too, see the law as unwise and costly in many regards. ☐

Thought Starter

The pattern of providing all or most of the training and education of medical students at a medical college would be like educating a forestry major at only a lumber yard.

— John G. Freymann, M.D.
Boston

EDUCATION'S SHARE OF GROSS NATIONAL PRODUCT



Over the past generation, the percentage of the gross national product (GNP) spent on education has varied considerably—from a low of 1.8 to a high of 6.6 percent—but the trend has been steadily upward since 1943. The 1965-66 school year (the latest comparable period) ranked high both in terms of total school expenditures and share in the GNP.

Speaking of Malpractice Insurance....

Have you checked the advantages of insuring with Shelby Mutual Insurance Company? This plan is sponsored by Michigan Association of the Professions and is available to members of the Michigan State Medical Society.

Here is why it might be beneficial for you to investigate

* Very Broad Coverage

* Competitive Premiums as Shown Below

Limits	Class 1	Class 2	Class 3	Class 4	Class 5	Premises Minimum Premium
100/300,000	$97.00	$170.00	$292.00	$389.00	$486.00	$33.00

(Premises Coverage Required with Professional Liability)

Class 1 — PHYSICIANS — No surgery.

Class 2 — PHYSICIANS — Minor surgery or assisting in major surgery on own patients.

Class 3 — SURGEONS — General practitioners who perform major surgery or assist in major surgery on other than own patients.

Class 4 — SURGEONS — Specialists.

Class 5 — SURGEONS — Specialists — Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists.

Write for complete information as to coverage and premiums.

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Gotta make a pit stop to take my cough syrup.
Full speed ahead, Fred. These solid Cough Calmers can control that cough for 6 to 8 hours.
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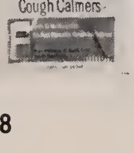
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Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

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Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

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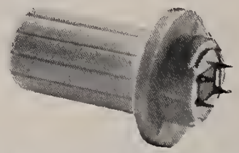
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
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The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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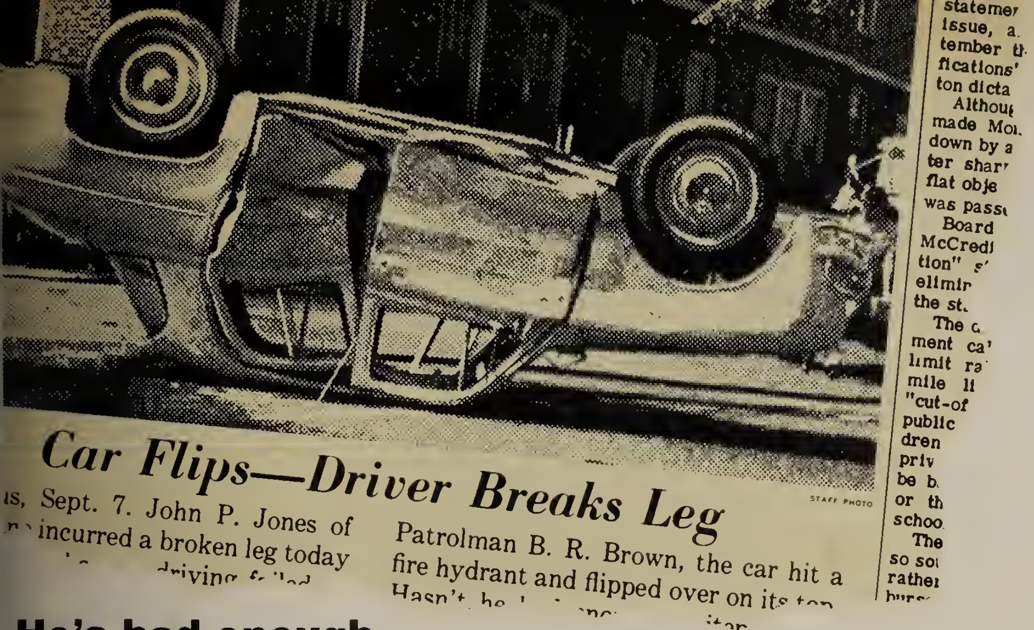
Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



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STAFF PHOTO

Car Flips—Driver Breaks Leg

is, Sept. 7. John P. Jones of incurred a broken leg today

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
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a comprehensive hematinic

Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires approp
investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adec
vitamin B_{12} therapy may result in hematologic remission but
rological progression. Adequate doses of vitamin B_{12} (paren
or oral with potent intrinsic factor as in Trinsicon® [hema
concentrate with intrinsic factor, Lilly]) usually prevent, ha
improve the neurological changes.

As with all preparations containing intrinsic factor, resis
may develop in some cases of pernicious anemia to the pot
tion of absorption of physiological doses of vitamin B_{12}. If r
ance occurs, parenteral therapy, or oral therapy with so-c
massive doses of vitamin B_{12}, may be necessary. No single
men fits all cases, and the status of the patient observ
follow-up is the final criterion for adequacy of therapy. Pe

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nical and laboratory studies are considered essential and are
ommended.
verse Reactions: In rare instances, iron in therapeutic doses
oduces gastro-intestinal reactions, such as diarrhea or consti-
tion. Reducing the dose and administering it with meals will
nimize these effects.
In extremely rare instances, skin rash suggesting allergy has
lowed oral administration of liver-stomach material. Instances
apparent allergic sensitization have also been reported after
al administration of folic acid.
sage: One Pulvule twice a day. (Two Pulvules daily produce a
ndard response in the average uncomplicated case of perni-
us anemia.)
w Supplied: Pulvules Trinsicon® (hematinic concentrate with
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In peptic ulcer:

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"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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See inside fold for product summary.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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BOOK REVIEWS

HEREDITY, DISEASE AND MAN: GENETICS IN MEDICINE. By Alan E. H. Emery. $6.95 247 pp., illustrated. University of California Press, Berkeley and Los Angeles, 1968.

This book presents a very excellent review of our present knowledge of genetics as it relates to man. The author, Doctor Emery, is Chairman of the Department of Human Genetics at the University of Edinburgh. The text is very well written with clear explanations and good illustrations of the more complicated aspects of cytogenetics. Since this was not intended to be a textbook for students in medicine, some parts of the material are somewhat superficial. An example of this is the description of DNA and the chemistry of genes in which many of the details are omitted. To compensate for this are the frequent references to historical development of various aspects of genetics that often are not included in the more rigid frame of a textbook.

The material covered is quite comprehensive beginning with the chemical basis of inheritance and the description of DNA and RNA. The chromosomes and chromosomal abnormalities are discussed and illustrated. It is unfortunate that photographs were not used instead of line drawings to illustrate some of the abnormalities that are described throughout the text. The line drawings simply do not adequately portray the characteristic findings for the reader who is unfamiliar with them. Methods of inheritance such as dominant, recessive and sex-linked aspects are very adequately described. An unusual and very excellent chapter is that on pharmacogenetics. The material presented here is often omitted from other books on the subject. It seems to this reviewer that this chapter conveys as well or better than most others the intricacies of the influence of genetics on our lives other than the purely structural ones. Population and natural selections are discussed as well as the effects of radiation of human hereditary. A ten page glossary adds considerable value to the book and makes it easier for the reader to look up unfamiliar words rather than referring back to the chapter in which these words first appeared.

Any physician who is interested in genetics would benefit by reading this text. If he has kept up with developments by reading the review articles as they appear in our medical journals, he probably will find the presentation by Doctor Emery to be too superficial to be of great value to him. If, on the other hand, the physician wants a good review that is not too complicated, this book would adequately fill that need. The text is purely descriptive and no techniques or details of methods are given. Most chapters are followed by a very adequate though brief list of references. With the exception of lack of photographs, the illustrations are excellent and supplement the text very well.

George H. Lowrey, M.D.

SEES STATE MEDICAL JOURNAL ROLE INCREASING

The state medical society journals, I firmly believe, will be of even greater value in the future. The state medical society journals in coming years will provide more essential information to physicians in such areas of growing importance as socioeconomics and legislation.

—GEORGE F. LULL, M.D.
—EXECUTIVE SECRETARY
ILLINOIS MEDICAL SOCIETY

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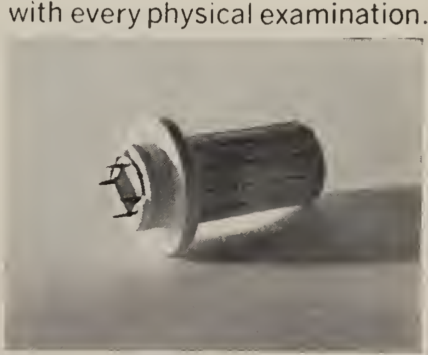

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Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

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A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

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*lease see Brief Summary
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Brief Summary

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Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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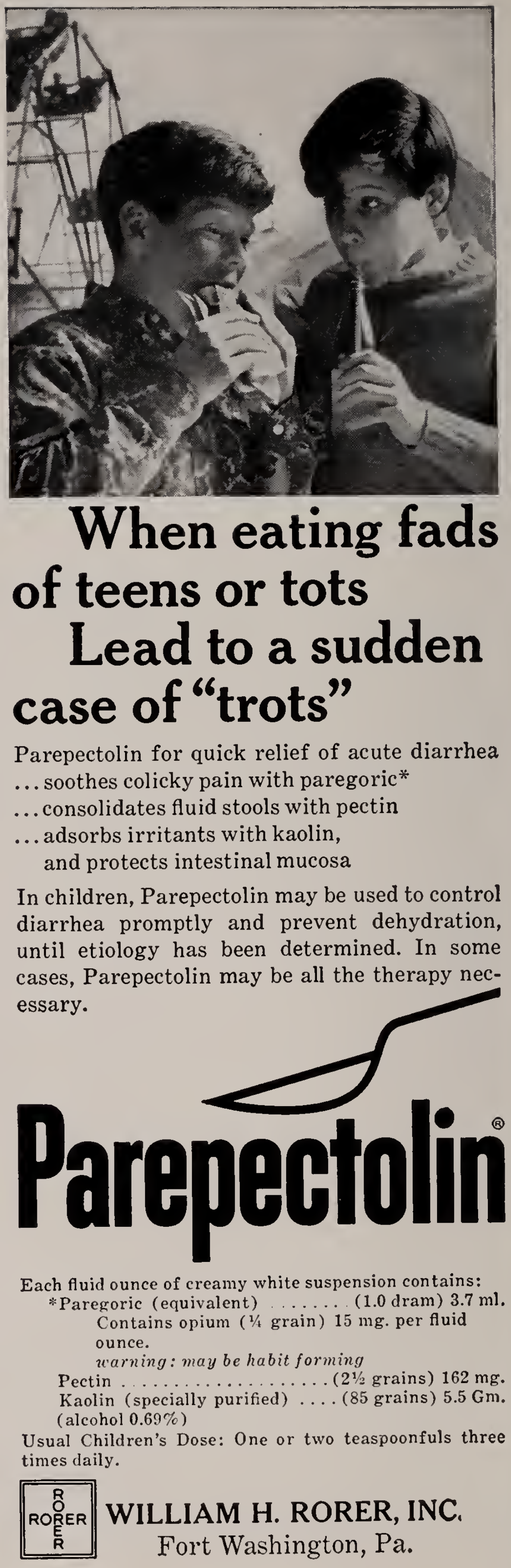

When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
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In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) .... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
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Review of "Prevention of Highway Injury," edited by Melvin L. Selzer, M.D., Paul W. Gikas, M.D., and Donald F. Huelke, Ph.D. and published by the University of Michigan, Ann Arbor, Michigan.

This is a book of thirty chapters individually written by authors from the United States, Canada and Europe, and divided into four general headings of The Alcoholic Driver, Vision and Medical Impairment, Biomechanics, and The Second Collision. The material in the first two general headings is of greater practical value to the physician interested in traffic safety. I would recommend especially the two articles written by Julian A. Waller, M.D., of the California Department of Public Health: Drinking Drivers and Driving Drinkers — The Need for Multiple Approaches to Accidents Involving Alcohol; and The Contribution of Medical Impairment to Traffic Accidents.

In the first chapter, Doctor Waller emphasizes the now accepted fact that the majority of drinking accidents and violations involve persons with alcoholism, and that the current practice of emphasizing moral responsibility with slogans such as, "If you drive, don't drink," and with heavy fines and suspension of licenses for drunken driving will have little or no beneficial effect. For many persons with alcoholism the driver's license will have to be revoked until the alcoholism improves under treatment. He suggests that many social drinkers do drink and drive despite admonition, and that we can teach them how to limit their risk by eating with their drinks, by not drinking more rapidly than they can metabolize their alcohol (about one hour for each drink), and by waiting at least a half hour after their last drink before driving.

In the chapter on Medical Impairment, Doctor Waller makes several interesting observations based on available studies from a number of sources. Acute medical conditions are not felt to be an important cause of accidents. However, more subtle physiologic changes related to aging and chronic conditions appear to be a contributory factor in a substantial proportion of accidents. Medical impairment from chronic conditions other than alcoholism in a factor in 15-25 percent of all accidents. However, licenses should be revoked only for persons with the most severe illness, representing, at most, a third of the medical groups and five percent of all drivers. This is the group with accident risk in excess of 3-4 times that of the general population.

This book has two minor deficiencies. The type is considerably smaller than that used in current medical texts and magazines. An additional 75 pages would have produced a more easily read book. Also, only two chapter authors out of thirty had summaries at the beginning of their chapters.

John R. Rodger, M.D.
Bellaire, Michigan

State Researchers Work On Adenine Project

Research scientists at the Michigan Department of Public Health are taking part in an investigation to determine if a new additive, may be suitable for prolonging the useful life of donated blood. The Michigan study is primarily concerned with the effect of adenine on the various blood products that are made from whole blood.

The study is financed by a contract of $65,765 from the U.S. Public Health Service's National Heart Institute.

Previous studies by army researchers and other scientists have established that adenine can extend the useful life of blood. There is evidence that blood containing this additive can be stored safely for up to 42 days instead of the normal maximum of 21 days. If this proves to be true, better utilization of whole blood can be achieved and thus help meet the increasing military and civilian needs.

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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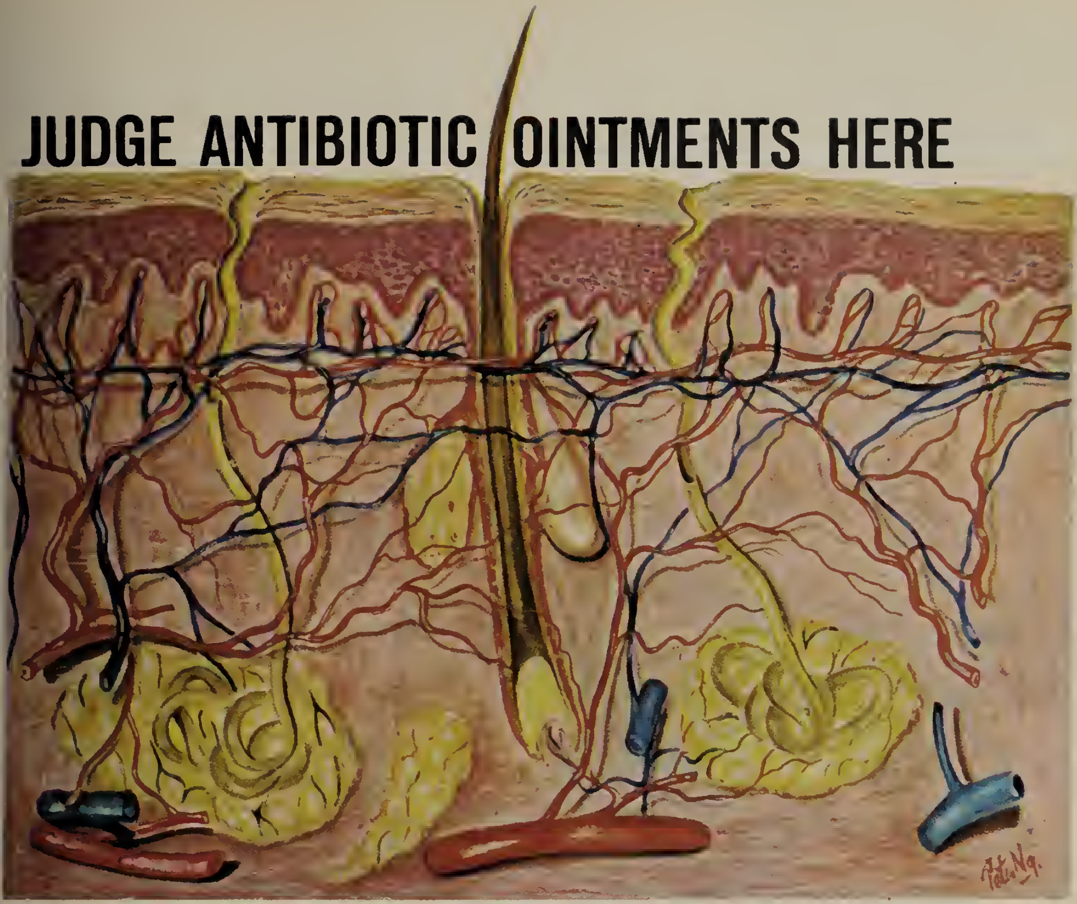

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
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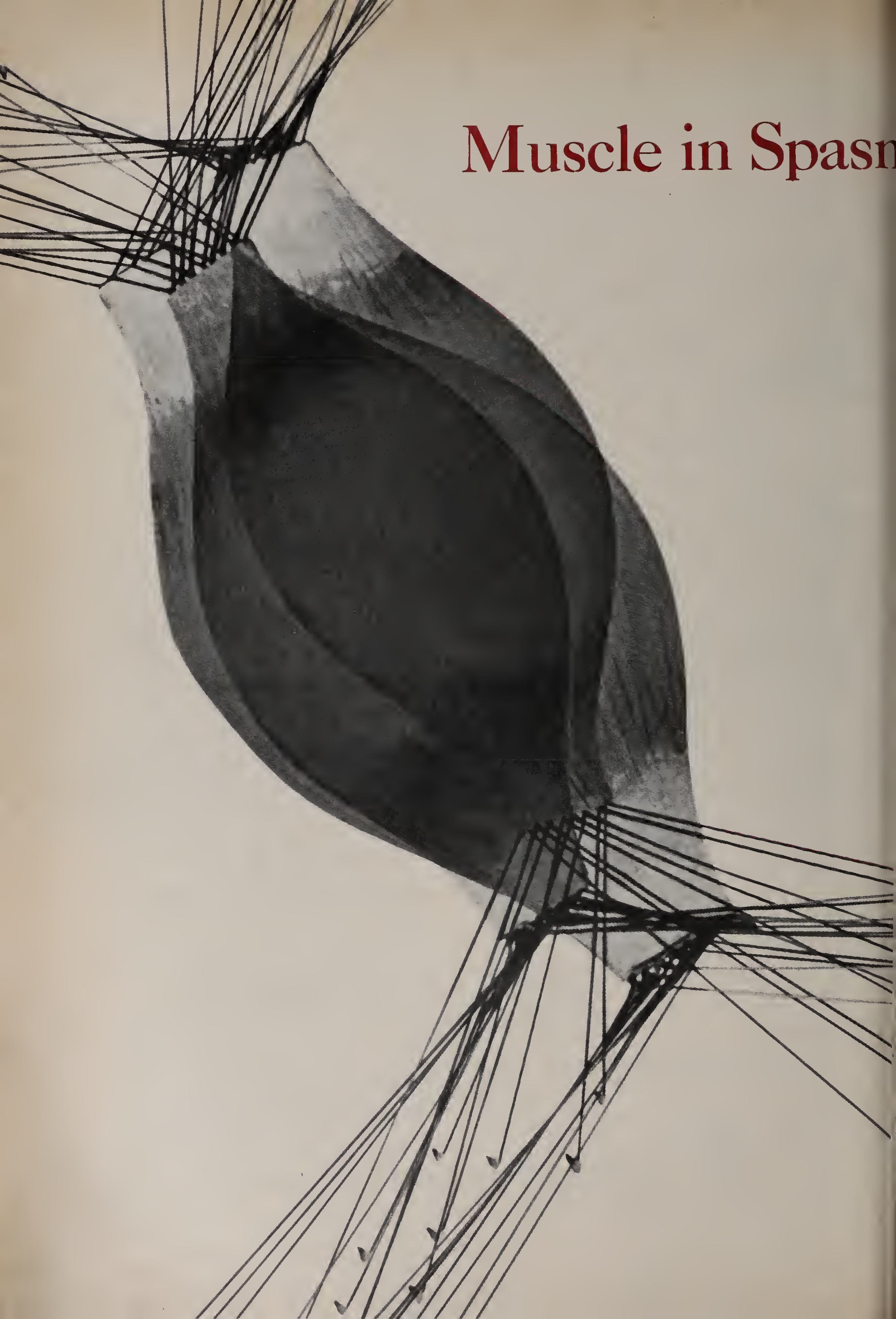
Muscle in Spasm



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The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)R 46-070-A

For complete details, please see full prescribing information.

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Power Mower Injuries Of the Hand

J. JOSEPH DANYO, M.D.
YORK, PA.
KIM K. LIE, M.D.
ROBERT D. LARSEN, M.D.
JOSEPH L. POSCH, M.D.
DETROIT

INTRODUCTION

During the past 25 years the power lawn mower industry has achieved a substantial volume of sales. The industry came of age with the advent of the rotary unit, which was developed as a means of coping with the steel shortage during World War II. Mowers prior to that time were of the reel type.

The power mower market in the United States is reliably reported as consisting of 25 million units. Upwards of five million new mowers are sold yearly, and of these, one million units are purchased by new owners.[1]

These convenient labor-saving machines are a boon to the welfare of our landscape and leisure time, but if handled incorrectly, they can become a menace to our families and neighbors. The industry has waged an excellent campaign of power mower safety for the past 12 years. And manufacturers are designing their machines to lessen the possibility of accidents occurring from missiles and direct contact with moving parts. Yet, the number of accidents continue to rise in astronomical proportions. Most mishaps nowadays, are due to the operator's carelessness.

There is no accurate estimate of the number of power mower injuries occurring in the United States. McClure[2] reported a series of 794 injuries in a survey in Georgia in 1955 and 1956. Of these injuries, 553 were caused by direct contact, and 143 cases involved injuries to the hand or fingers. Permanent disability occurred in 14 per cent of the cases. Two types of injuries were noted: one type due to direct contact, which occurred in 70 per cent of the cases; and another type due to missiles thrown by the power mower in 30 per cent of the cases. McClure[3] mentioned three reasons for the occurrance of accidents.

1. Faulty design of the mower.
2. Carelessness of the operator.
3. Injuries by missiles which are thrown by the power mower or fragments of mower blades.

Bergman[4] reported on a series of 110 power mower injuries during a five-month period. The severity of the injuries was apparent because 30 per cent of cases required hospitalization.

CASES

Our study deals with 110 power mower injuries of the hand encountered in private practice from 1954 to 1967 inclusive. The age of the patients ranged from 2 to 83 years. The average age of the patient was 32 years. The majority (85 per cent) of the patients were male. Children under 14 years of age were involved in 23 cases. Permanent disability in children occurred in 30 per cent of the cases. Of note was the fact that virtually all of the injuries to children occurred while the power mower was unattended and the motor was running.

Eighty-five per cent of the cases were severe injuries requiring hospitalization for surgical repair. The right hand was involved in 55 per cent of the cases and the left hand in 45 per cent. Single digit injuries occurred in one-third of the cases. The remaining two-thirds of the cases involved two to four digit injuries, and in four cases all digits on the hand were injured. In addition to soft tissue injury, 80 per cent of the cases had an injury to the bony structure. Thirty per cent of the injuries resulted in amputation of the digit. Permanent disability occurred in 23 per cent of the adults. The average loss of time from work in the adults was six weeks.

ETIOLOGY

In our series, our patients readily admitted to being at fault. The rotary mower was involved in 91 per cent of the cases, and the reel type mower in 9 per cent of the cases. By definition, the rotary mower is one that has a horizontal blade (s) that rotates about a vertical axis, cutting by velocity alone, without a stationary bed-knife. Rotary cutter blade speed is 21,000 feet-per-minute.[5] These

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Doctor Danyo, a fellow in hand surgery and formerly at Grace Hospital, Detroit, is now in York, Pa. Doctors Lie, Larsen and Posch are all with the Department of Surgery at Grace.

figures compared exactly to the ratio of the same mowers in use today.

No particular brand of rotary mower stood out above the others in accounting for the accidents. In 82 per cent of the cases the motor was running at the time of the injury. Wet grass with resulting clumping accounted for 25 per cent of the cases. In these instances, the wet grass clumps led the operator to reach into the opening in the blade housing without knowing the close proximity of the blade to the grass discharge chute. The guard was absent over the blade in 51 per cent of the cases. However, the guard was cited as being solely responsible for the injury in 33 per cent of the cases.

TREATMENT

The majority of our cases required hospitalization for surgical debridement and repair. Surgical debridement of the badly crushed digits was performed, and where primary closure was not possible, free skin grafts or cross finger pedicle grafts were performed. Thirty per cent of our cases required amputation of the injured digit. Open reduction and immobilization of fractures was required in 60 per cent of the cases. Associated tendon injuries were not repaired primarily.

CONCLUSIONS AND SUMMARY

Power mower injuries will continue to be more prevalent commensurate with the increased use of these appliances. Direct contact injuries are caused by carelessness of the operator. The majority of the cases required hospitalization for surgical repair. The average length of temporary disability was six weeks, and permanent disability resulted in 23 per cent of the adults. Multiple digit injuries were noted in 70 per cent of the cases. It is apparent that power mower injuries caused by direct contact are severe disabling injuries resulting in economic hardship. Better public awareness on the inherent dangers of power lawn mowers is imperative to prevent these injuries. A nation-wide safety educational program directed to the manufacturers, sellers and users of power mower equipment is necessary.

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Evaluation of a Screening-Technique For Urinary Tract Infections In Diabetic Out-Patients

ABSTRACT

Significant urinary tract infections have been demonstrated in 14.6 percent of a randomly selected group of 212 diabetic out-patients. A commercial screening test (Testuria) has also been evaluated as a means of identifying such patients. Properly safeguarded, the screening test has been found to be useful in the management of an out-patient population. No false negatives were recorded; a negative Testuria result was always associated with a negative quantitative agar plate culture. But the incidence of false positives was high. Some 30 percent of all positive Testuria results were associated with insignificant colony counts on hospital agar plates in single comparison studies.

"Suspicious" or positive results with Testuria should be confirmed by standard agar plating of another urine specimen before diagnostic or therapeutic decisions are taken. Negative results with Testuria may be accepted at face value.

BY ALI ABBASI, M.D.
LAWRENCE POWER, M.D.
DETROIT

INTRODUCTION

Urinary tract infections are common in patients with diabetes mellitus. They have been reported to be 3-4 times more common in diabetic populations by autopsy studies,[1, 2] renal biopsy,[3] and clinical studies.[4] Recent emphasis on the value of quantitative urinary bacterial cultures in identifying significant urinary tract infection had led to the development of a number of procedures for this purpose.[5] In the present study we have compared the results obtained with a commercially-available urine culture technique (Testuria) with a standard hospital agar plate procedure, in a diabetic out-patient population.

MATERIALS AND METHODS

During the study, 212 randomly-selected outpatients with diabetes mellitus were screened for urinary tract infections. The study was done over an 8-month period during two clinic mornings each week. The composition of the population is shown in Table 1 and the modes of management of their diabetes in Table 2. A mid-stream clean catch specimen was obtained by the patient after instruction from the nurse. The external genitalia of both male and female patients had been washed with a solution of green soap and 1:1000 zephiran. Routine chemistries and a microscopic examination were also performed on each urine specimen.

TABLE 1

Types of Patients Screened

	Number	Negro	White	Mean Age
Female	144	123	21	55
Male	68	46	22	57
Total	212	169	43	56

TABLE 2

Diabetes Management of the Screened Patients

Treatment	Number	Percent
Insulin	96	45
Chlorpropamide	52	24.5
Tolbutamide	26	12.2
Phenformin	3	1.4
Phenformin and Sulfonylurea	12	5.6
Diet Alone	16	7.5
New Patients	9	4.2

Doctor Abbasi is a resident in Endocrinology and Metabolism at Detroit General Hospital, and Doctor Power is Associate Professor of Internal Medicine and Chief of the Section of Endocrinology and Metabolism at the Wayne State University School of Medicine Department of Medicine.

In the technique followed, an inoculum of the specimen was delivered to Testuria plates by means of the filter paper strip which comes with the plates, was dipped into the urine, and applied to the culture medium. The plate was then incubated in the supplied incubator at 37° C. for 24 hours, and the number of colonies counted.

After Testuria plating, the remaining urine was sent to the bacteriology laboratory of Detroit General Hospital and plated by means of a standard loop designed to handle 0.01 ml. Gram positive organisms were sought on an eosin methylene blue medium, and colony count estimates made the following day. Atypical organisms and non-lactose fermenters were further identified through standard bacterial-biochemical flow techniques.

RESULTS

A total of 212 patients were studied and 288 paired Testuria and agar plate cultures performed. Testuria colonies were counted and classified into three groups: Group I contained 0-2 colonies; Group II, 3-25 colonies; Group III, more than 25 colonies. As suggested by the manufacturer, Group I was considered equivalent to a quantitative plate count of less than 25,000 bacteria per ml. of urine, and interpreted as negative. Group II was considered to be "suspicious," and the manufacturer recommends that cultures in this group be repeated. Group III was said to be equivalent to a quantitative plate count of 100,000 bacteria or more per ml. of urine. The results of our comparisons are shown in Table 3. More than 50,000 bacteria colonies per ml. of urine are considered, at this hospital, to signify a urinary tract infection.

Group I or negative culture results (Table 3) were in agreement with the quantitative plate count. The great majority of Group II, or "suspicious" results did not signify urinary tract infection when compared to the agar plate standard. This tendency to over-diagnosis extended into the Group III comparisons where 16 out of 53 Testuria positives did not prove to be significantly infected by standard hospital agar plate comparisons.

Thirty-one of 212 screened patients had significant bacteriuria, for a prevalence of 14.6 percent. When sexes were considered separately, 5 of the patients were male, and 26 were female, for a 7.3 percent and 18 percent prevalence, respectively. Twenty-four patients were asymptomatic, while 9 (22.5 percent) had mild-to-moderate symptoms, such as dysuria and back or flank discomfort. No patient was febrile. The incidence of comparable symptoms in those patients screened who did not have significant bacteriuria, was 17.6 percent (32 of 181), and indicates the need for a routine screen for infection regardless of the patient's symptoms, or lack of them. Proteinuria was demonstrated in 66.6 percent of the specimens from patients with bacteriuria, while it was present in only 36.9 percent of the specimens of patients without significant bacteriuria.

Examination of centrifuged urinary sediments (Table 5) revealed a significant deposit of bacteria (++ or more) in 63.6 percent of infected urine specimens, but in only 11.5 percent of uninfected specimens. Other findings on microscopic examination, such as white blood cells, mucus, and casts were not significantly different between infected and non-infected groups (Table 5).

TABLE 3

A Comparison of Testuria and Standard Quantitative Agar Plate Cultures

(Clean-catch Urine Specimens of Diabetic Out-patients)

Testuria Results	Agar Plate Results	Number of Comparisons
0-2 colonies	< 10,000	191
3-25 colonies	< 10,000	39
	10,000-50,000 ..	4
	> 100,000	1
> 25 colonies	< 20,000	16
	> 50,000	37

TABLE 4

Organisms Responsible for Urinary Tract Infections

(More than 50,000 Organisms per ml. on Agar Plate)

	E. coli	Aerobacter	Proteus	Gamma Streptococcus
Male	2	3	0	0
Female	17 (9 pts)	10 (9 pts)	4 (3 pts)	1
Total	19	13	4	1
Percentage	51.3%	34.1%	10.8%	2.7%

TABLE 5

Microscopic Findings in Urine Specimens Of Screened Diabetic Patients

Findings per high power field	Incidence	Percentage
++ or more bacteria	21 of 33 infected specimens	63.6%
	17 of 147 uninfected specimens	11 5%
more than 10 WBC	9 of 33 infected specimens	27.2%
	25 of 147 uninfected specimens	17%
more than 20 WBC	7 of 33 infected specimens	21.2%
	14 of 147 uninfected specimens	9.5%
Casts	10 of 33 infected specimens	30.5%
	55 of 147 uninfected specimens	36.0%

DISCUSSION

The prevalence of urinary tract infections in our male and female diabetic out-patients, as revealed by this study, is 14.6 percent. When the sexes are considered separately, 7.3 percent of the screened males and 18 percent of the screened females have significant bacteriuria. Observations in this range have been reported by other workers[6, 7] and underline the need for a routine screening procedure among diabetics, whether they are symptomatic or not, if infection is to be recognized and functioning tissue saved. Testuria provides help in this objective, but tends to err on the side of false positives. Positive or "suspicious" results with Testuria are an indication for repeat evaluation of the patient and standard agar plating of another urine specimen. Our experience indicates that negative results with Testuria are quite reliable.

Sixteen specimens in Testuria Group III yielded quantitative agar plate counts of less than 20,000 bacteria per ml., but in 5 of these specimens there were several grossly different bacterial colonies. This in itself suggests contamination. If these 5 specimens are disregarded, the false positives occurring with Testuria culture become 11 of 288 urine specimens, or 3.8 percent. The likelihood that a positive Testuria result signifies urinary tract infection is increased if the urine specimen also contains protein and shows deposits of bacteria in the centrifuged sediment.

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The Treatment of Trigeminal Neuralgia And Other Facial Pain with Carbamazepine

BY K. I. KILUK, M.D.
R. S. KNIGHTON, M.D.
J. D. NEWMAN, M.D.
DETROIT

In recent years, there have been many reports in the literature on the successful treatment of trigeminal neuralgia with Carbamazepine (5H-dibenz- [b, f]-azepine-5-carboxamide),[1-7] an anticonvulsant drug developed by Geigy Pharmaceuticals. The brand name is Tegretol.®

This paper will report our experience in treating 192 patients. Table I summarizes our initial group of 123. Ninety-eight patients had true paroxysmal pain in the distribution of the trigeminal or glossopharyngeal nerve. Sixteen patients had facial pain which did not meet the characteristic features of trigeminal neuralgia, either by type, location or duration of symptoms. The remaining nine patients were treated with Tegretol in the hope that it would help in the management of these difficult problems.

In the initial 18 months of our use of Tegretol, the active compound was compared with a placebo in a double blind study. Tegretol or the placebo was given to the patients in previously coded packages. The patients were re-evaluated after a few weeks, the code was checked and if they were on the placebo and without relief, they were given the active compound. As soon as we were convinced the Tegretol was effective (Table II), we discontinued the double blind study. The placebo was effective in only 10 percent, compared to 71.3 percent when Tegretol was given.

Tegretol is an iminostilbene derivative related to the tranquilizer, Tofranil.® It is not related to diphenylhydantoin.[8] The usual starting dose was 100 milligrams, three times per day. The patient obtained relief on this dosage usually within 12

TABLE I

CONDITIONS TREATED

Trigeminal neuralgia	90
Trigeminal neuralgia and M.S.	4
Atypical facial pain	15
Atypical facial pain and M.S.	1
Glossopharyngeal neuralgia	4
Post-herpetic pain	4
Tabetic pain	1
"Thalamic" pain	2
Hemifacial spasm	1
Pain related to neoplasm	1
TOTAL	123

TABLE II

RESULTS OF DOUBLE BLIND STUDY

	TEGRETOL		PLACEBO		TEGRETOL AFTER PLACEBO	
	RELIEF	NO RELIEF	RELIEF	NO RELIEF	RELIEF	NO RELIEF
Trigeminal neuralgia	30	7	2	14	12	1
Atypical facial pain	1	5	0	3	1	0
TOTAL	31	12	2	17	13	1
	(71.3%)	(28.7%)	(10%)	(90%)	(92.8%)	(7.2%)

TABLE III

RESULTS OF TEGRETOL

	SATISFACTORY		UNSATISFACTORY	
Trigeminal neuralgia	79	(88%)	11	(12%)
Atypical facial pain	3	(20%)	12	(80%)
Other conditions	2*	(14.6%)	11	(85.4%)

* Glossopharyngeal neuralgia

Doctor Kiluk and Doctor Knighton are associated with the Department of Neurosurgery and Doctor Newman with the Department of Neurology, all at Henry Ford Hospital, Detroit.

hours. If this was insufficient, the dosage was increased after a few days to 200 milligrams, three times a day. After relief was obtained, the dosage was decreased to the lowest dosage which offered satisfactory relief and frequent attempts were made to discontinue the medication.

In the initial two years of the study, treatment was limited to three months by Federal Drug Administration Regulation. Later, this period was extended and finally removed.

RESULTS OF TREATMENT

A satisfactory response consisted of enough pain relief so that the patient desired to remain on the medication. There was complete pain relief in almost all of the cases. The medication was given to 118 of the 123 patients; the other five received the placebo alone. Trigeminal neuralgia had a favorable response in 88 percent of the cases. Only 20 percent of the patients with atypical facial pain had a satisfactory response (Table III). Of the remaining 13 patients, only two obtained satisfactory relief and both of these had glossopharyngeal neuralgia. Ninety patients had trigeminal neuralgia. Complete pain relief was obtained in 46.6 percent of these patients when they were on the medication (Table IV). The pain returned immediately when the medication was stopped. Of the remaining patients who had complete relief, 14.4 percent had only initial relief with the pain returning while they were on the medication and 14.4 percent had no return of the symptoms when the medication was stopped. This last group of patients probably was in a period of remission that is usually seen in trigeminal neuralgia.

In our final tabulation, we include 69 additional patients, bringing the total number to 192 patients treated with Tegretol. Of this total, 48 patients with trigeminal neuralgia underwent surgical procedures for further relief of symptoms. Table V lists the reason for the surgical treatment. In addition, three patients refused to take the medication when offered.

TABLE IV

TYPE OF RESPONSE TO TEGRETOL IN TRIGEMINAL NEURALGIA

RESULTS	No.	%
No relief	9	10
Moderate relief	8	8.8
Complete relief		
While on medication	42	46.6
Transient	13	14.4
Permanent	13	14.4
Permanent on medication and surgery	5	5.8
TOTAL	90	100.0%

SIDE EFFECTS

Tegretol is a potent drug with frequent side effects, mainly dizziness, ataxia, nausea and vomiting (Table VI). Most of the side effects are transient and either disappear after a few days or by a reduction in the dosage. A large number, however, were considered severe enough to necessitate stopping the medication. These side effects usually cleared rapidly when this was done.

A white blood count, hemoglobin, reticulocyte count and blood smear were obtained every two weeks, and a serum creatinine, transaminase, urine analysis and alkaline phosphatase every four weeks.

One death occurred due to aplastic anemia and toxic hepatitis. This patient refused to get the re-

TABLE V

REASONS FOR SURGERY IN PATIENTS WITH TRIGEMINAL NEURALGIA AFTER TEGRETOL TRIAL

Good relief but desired more permanent cure	10
Good relief but severe side effects	7
Inadequate relief	
No relief	12
Moderate relief	9
Transient relief	10

TABLE VI

SIDE EFFECTS DUE TO TEGRETOL

SIDE EFFECT	TRANSIENT	SEVERE
Dizzy or ataxic	18	11
Nausea and/or vomiting	6	2
Drowsy	3	3
Rash	1	2
Multiple sclerosis worse	1	2
Abnormal liver function test	0	2
Numbness	1	0
Aplastic anemia and toxic hepatitis	0	1*

* Death

quired laboratory tests in the last two months of treatment, although he was warned repeatedly about the potential hazards of the medication. The aplastic anemia was discovered when the patient underwent emergency surgery for an incarcerated hernia. He had not been taking any other medication at the time and no other cause was found.

A second patient had an elevation in the transaminase, alkaline phosphatase and bilirubin. The jaundice was due to intrahepatic bile stasis and slowly improved when the medication was stopped. A liver biopsy revealed a normal liver architecture with much bile pigment compatible with intrahepatic cholestasis. No other cause for the jaundice was found when the patient was worked up.

DISCUSSION

The mechanism of the pain production in trigeminal neuralgia is still undetermined. There are two primary theories about the etiology of trigeminal neuralgia: One is peripheral; and the other central.

Dandy[9] in 1934 thought that the cause of trigeminal neuralgia was located peripherally in the sensory root of the trigeminal nerve. The fifth, seventh, ninth and tenth cranial nerves are all subject to tic pain. All of these roots have parasympathetic fibers, including the fifth nerve.[10] The parasympathetic fibers of the trigeminal nerve are thought to innervate the erectile tissue of the vibrissae which are present in lower mammals.

Gardner[11] postulated that trigeminal neuralgia is the result of a retained phylogenetic reflex. The afferent tactile stimulus causes an afferent (parasympathetic) response which excites the pain fibers through an artificial synapse produced by pressure on the nerve root. The pressure causes a localized demyelination and short circuits two adjacent axons. Electron microscopic examination of the ganglion cells of the trigeminal nerve showed vacuolation and segmental demyelination with denuding of the axis cylinders.[12] The various causes of pressure on the root have been arterial compression,[13] petrous ridge compression,[14] aneurysm, tumors and the internal carotid artery.[15]

The central etiology of tic douloureux has been extensively investigated and supported by King.[16] Stimulation of the infraorbital nerve in a cat gives an afferent spike followed within 5 m. sec. by a complex of deflections from the brain stem to the periphery. This is thought to be a dorsal root reflex.[17] This reflex is probably polysynaptic as is the linguo-mandibular reflex which is depressed by Tegretol. This reflex can be increased by strychnine injections in the region of the nucleus caudalis of the fifth nerve[16] with a marked over-reaction to a light tactile stimulus in the distribution of the trigeminal nerve. King thinks that a wide number of lesions within the central nervous system affect the excitability of this system which has its synapse in the nucleus caudalis. Lidocaine, Hydantoin and possibly Tegretol depress this reflex.

Strychnine renders the nervous system more excitable by lowering the threshold of excitability, by preventing the loss of excitability from continuous stimulation and by prolonging the period of hyperexcitability which normally follows nerve stimulation.[18] Tegretol has a prominent anticonvulsant effect with respect to strychnine and counteracts these effects. Tegretol possibly does the same in trigeminal neuralgia by raising the threshold of excitability and by interrupting the period of hyperexcitability caused by either (1) short circuiting of two adjacent damaged neurons, as in the peripheral theory of trigeminal neuralgia or (2) by an increased dorsal root reflex from a central cause.

Our results are in agreement with the studies in the literature.[1-7] We have found Tegretol to be very effective in the treatment of trigeminal neuralgia and also some use in glossopharyngeal neuralgia. It is generally ineffective in treating atypical facial pain and is about the same as the placebo. Unfortunately, the incidence of side reactions are high and potentially dangerous. There have been three other reported cases of aplastic anemia.[5, 19] This is by far the most serious of the side effects and frequent laboratory tests must be made as suggested by the manufacturer. In our experience, a large number of the patients eventually ask to have a surgical procedure done, which has proved to be less costly, more permanent, and is free of serious complications.

In our opinion, Tegretol will have its greatest use in:

1. Patients with an acute attack of trigeminal neuralgia while they are awaiting surgery.
2. Patients who are poor surgical risks because of age or health.
3. Patients in whom the diagnosis is not clear and further time for evaluation is necessary.
4. Patients who would prefer to postpone a surgical procedure.

It should not be used in treating atypical facial pain or other pain problems because of its toxicity and lack of effectiveness in these conditions.

SUMMARY

One hundred ninety-two cases of trigeminal neuralgia, atypical facial pain, and various other conditions were treated with Tegretol. Three to six hundred milligrams of Tegretol were sufficient to stop 88 percent of trigeminal neuralgia within one day. It was ineffective in treating atypical facial pain and was moderately effective in glossopharyngeal neuralgia. The medication has frequent and potentially serious side effects and one of our patients died from aplastic anemia. Although the medication is effective, many of the patients eventually decided on surgical procedure for more permanent control because of the reasons listed in Table V.

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Acute Myocardial Infarction Preceding Diabetes Mellitus

BY MARJORIE PEEBLES-MEYERS, M.D.
DETROIT

That diabetes mellitus occurring in persons under fifty years of age (and probably at any age) is an accelerating factor in atherosclerosis has been well known for many years.[1,2,3] This is well illustrated by the higher frequency of coronary artery disease and peripheral vascular disease in the diabetic population as compared to the general population.[2,4]

Over the past several years we have become increasingly aware that some patients suffering from myocardial infarction may have hyperglycemia. This abnormality reverts to normal within a few days in the majority of cases, but often a few patients will continue as true diabetics. In one series, Wahlberg of Sweden subjected 190 survivors to intravenous glucose tolerance tests after recovery from their initial attack of myocardial infarction, and found frank diabetes in 12% of those under 50 years. The prevalence increased with age.[5]

This is one side of the coin. The following case history illustrates the obverse — namely, that myocardial infarction may portend diabetes.

J.P., A THEN 47-YEAR OLD MALE EXECUTIVE, was seen initially because of the sudden onset of nausea and vomiting occurring sporadically during the preceding night, but unaccompanied by chest or abdominal pain. Blood pressure, pulse, respiration were normal. Temperature was 100°F. Except for a murmur consistent with mitral stenosis, no other abnormalities were noted.

The patient had scarlet fever at ten years of age. His family was informed that he had developed a "heart murmur." Despite this the patient maintained an active life without restrictions.

There was no known family history of diabetes, but his father, a paternal uncle, and an older brother all had died of coronary artery disease prior to 50 years of age. Though hypertensive, his mother was alive at 78 years as were four siblings. While hospital arrangements were in progress, the patient became sweaty and anxious. On re-examination the blood pressure was 60/40. Atrial fibrillation with a rapid ventricular rate was observed. The admitting electrocardiogram confirmed the arrhythmia and revealed an extensive acute anterior myocardial infarction.

On admission and during his hospital stay fasting and post-prandial blood sugars were normal. One year later on routine examination following a three-day, 300-gram carbohydrate diet, a four-hour oral glucose tolerance test was normal. Two years later a two-hour post-prandial blood sugar was 170 mg. per 100 ml. (true glucose). The patient was asymptomatic and had not regained his pre-infarct weight. A four-hour glucose tolerance curve at this time was positive for diabetes. With dietary manipulation, the patient has maintained excellent control of his blood sugar levels.

This case merely serves to highlight the fact that acute myocardial infarction may be a "prediabetic" sign. Following myocardial infarction, patients should be evaluated at appropriate intervals for diabetes.

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Faulty Neurologic Integration With Perceptual Disorders in Children

AN ABRIDGED TREATMENT APPROACH; A TWO-DIMENSIONAL PROGRAM OF METHYLPHENIDATE AND PSYCHOLOGIC MANAGEMENT

ABSTRACT: The high incidence of learning disorders among school children, based on perceptual abnormalities with concomitant emotional problems, poses a burdensome responsibility on the community and the medical profession. Various modalities, involving prolonged re-training in special clinics and institutions, have not only deferred beneficial gains for the afflicted children, but have permitted exploitation of their parents by para-, as well as pseudo-, medical groups. Such considerations have prompted our promulgation of a practical, expeditions approach to the therapy of perceptual disorders in children with faulty neurological integration, utilizing, for the most part, the services of a physician and clinical psychologist in a private practice setting. Our experiences with over 100 such cases are delineated; and, of these, 3 representative case histories are presented in detail. Methylphenidate, the drug of choice, together with psychologic support, effected highly successful results rapidly, and often dramatically.

BY SAMUEL J. NICHAMIN, M.D.
GEORGE D. BARAHAL, Ph.D.
BOTH OF DETROIT

During the past decade, educators, psychologists, and physicians have been inundated with a bewildering onslaught of investigations in the rapidly expanding field of learning disabilities associated with minimal cerebral dysfunction. Emotional problems engendered by a child's educational failures comprise an impressively large segment of the syndrome. Those concerned with emotional, psychologic, and environmental problems have been prone to ignore or neglect the use of drugs, whereas organicists have concentrated on psychopharmacologic products. Hence, no definitive therapy has been promulgated; and beneficial results, by and large, remain indeterminate for either modality. In such an area of indecision regarding effective therapeutic methods, parents, teachers, and patients can readily succumb to attitudes of frustration and despair.

The hyperkinetic syndrome, or its counterpart, the hypokinetic (lethargic) child with sluggish mentation, has a behavioral cluster which consists primarily of motor restlessness of varying degrees, impulsivity, and distractibility in perceptual and congnitive spheres. Comprehensive, basic data garnered for the study of this clinical entity, has hitherto necessitated the provision of a large, multidisciplinary staff organization, consisting of administrators, psychiatrists, pediatricians, opthalmologists, neurologists, psychologists, social workers, teachers, and speech or hearing specialists. For the practical application of available knowledge in this vital area of learning disorders, an extensive proliferation of these medical centers or child guidance clinics would be an unquestionable desideratum. However, in terms of community and financial resources, a requisite program for such elaborate complexes would represent an unattainable and realistic expectation.

To avoid semantic confusion in the nosology of brain dysfunction, with its implication of brain damage or mental retardation or both, we propose the term, "faulty neurologic integration with perceptual disorders" for children who are thus afflicted. In the psychologic and educational spheres, emphasis has centered on motor re-learning, with training exercises in coordination, remedial reading, and even cultist-type abstruse methods provided in special private schools and institutes, with results of questionable authenticity. Furthermore, these training procedures are prohibitively expensive and of prolonged duration.

Despite the gamut of disparate factors comprising this vital problem of perceptual and learning disorders in children, effective integration of all

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Generic and Trade Names of Drugs
Methylphenidate hydrochloride—Ritalin (Ciba)
Amphetamine sulfate—Dexedrine

relevant information from the various disciplines involved can be unreservedly entrusted to the family physician. In a simplified, basic, two-dimensional program of methylphenidate and psychologic management, the clinical psychologist performs an indispensable function. He is responsible for the assessment of all mental and emotional findings, and should be involved with every phase of treatment.

In the light of this joint endeavor, combining the medical and psychologic responsibilities in a private office type of practice, independent of an elaborate, and often redundant hierarchy of interdisciplinary functions, we are herewith presenting our experience with over 100 patients with this syndrome. Our primary remedial purpose was to limit our efforts to the use of a specific, psychostimulant drug (methylphenidate) of proven efficacious value in such children,[2,3,4] together with the provision of psychological support for the patient and family. The latter function does not imply exhaustive, long-term, intensive psychotherapy.

In view of the array of publications in this field, documented and qualified, it would appear redundant and beyond the scope of this paper for us to re-explore the areas of diagnosis and the neurophysiological theories for drug therapy of hyperkinesis with perceptual disorders. In accordance with Eisenberg's[3] studies and observations of these problems, we adhered to his two-dimensional program of stimulant drug therapy (methylphenidate) and supportative psychologic guidance. Our experience with more than 100 children diagnosed as hyperkinetic or lethargic, with associated malfunction of neurologic integration, cooroborates his optimistic conclusions that at least two-thirds or more[4] of these individuals show dramatic response by these methods. With a purported incidence of 10 to 20 per cent of the school population having learning or perceptual disorders, the promulgation of such a practical, expeditious approach to therapy, within the milieu of private medical practice, seems warranted.

METHOD OF STUDY

At the outset, children with these problems received a complete physical examination, covering all aspects of muscular, metabolic, and neurologic functioning. Significant areas in the history pertaining to prenatal, natal and perinatal incidents, as well as serious infections, were evaluated. It was our intention to screen out those children with overt symptoms or signs of brain damage, or whose history strongly suggested factors significant in the etiology of organic brain involvement. Neurologic consultations and EEGs were not routinely secured.

Psychologic evaluation was then carried out by the psychologist co-author. Psychologic tests included the Wechsler Intelligence Scale for Children (WISC), the Bender Gestalt, Frostig, figure drawing tests, and various standardized academic achievement tests, to determine grade-level functioning. Where indicated, personality tests (Rorschach, Thematic Apperception Test (TAT) were employed. Tests of laterality, stereogenosis, and visual and auditory perceptual tests (modified from Birch) were also included. Family imbalance and neurotic interaction were investigated, as well as inappropriate disciplinary management. Awareness of the strategic relevance of the family dynamics was a crucial aspect of the diagnostic and remedial program, as also stressed by Eisenberg.[3] It should not be inferred that, within the psychologic dimension, a prolonged, intensive program of psychotherapy was deemed inevitable. On the other hand, short-term supportive guidance proved to be practical, and entirely adequate.

In our study, methylphenidate was exclusively prescribed in doses ranging from 2.5 mg. twice daily, morning and noon, in the preschool child, to up to 20 mg. or more in the post-pubertal individual. The drug was initiated with relatively smaller doses and then gradually increased by small increments over a period of a week or two, in order to ascertain any evidences of intolerance or adverse side-effects. As treatment pro-

CHART

Methlyphenidate Dosage Schedule For Children With Faulty Neurologic Integration With Perceptual Disorders (Minimal Cerebral Dysfunction)

Age	Dosage
3 - 6 years	2.5 mg a.m. and noon for 3 days, then 5.0 mg a.m. and noon for 3 days, then 7.5 mg a.m. and 5 mg at noon, and then continued as directed.
6 - 12 years	5 mg a.m. and noon for 3 days, then 10 mg a.m. and noon for 3 days, then 15 mg a.m. and 10 mg at noon, and then continued as directed.
12 - 18 years	5-10 mg a.m. and noon for 3 days, then 15 mg a.m. and noon for 3 days, then 20 mg a.m. and noon, and then continued as directed.

gressed, continuing contact with the mothers prevailed until a requisite dosage level was established, capable of eliciting an optimum behavioral and cognitive efficiency. Bimonthly follow-up visits were routinely recommended. The relative absence of adverse side effects with this drug permitted its uninterrupted utilization over prolonged periods.

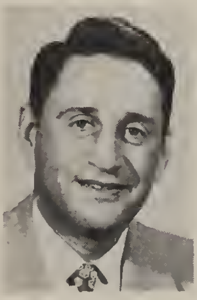
A survey in detail of each of our cases would be inappropriate in an article of this type. However, consideration of a few representative cases might clarify our procedures in the effective management of youngsters with perceptual disorders.

CASES

1. L. P. MALE, first seen at six years, four months of age. From infancy he had manifested extreme hyperkinesis, motoric and verbal, with disruptive behavior in kindergarten, home, and neighborhood. Impulsivity, awkwardness, and accident-proneness were present. All the usual management techniques were inadequate. The WISC revealed the following: Verbal IQ 135, Performance IQ 115, and Full Scale IQ 128 (very superior range). The most striking feature of Wechsler functioning in this very bright boy was the marked discrepancy between the Verbal and Performance IQs as noted. Visual perceptual disturbances were strongly evident. The Bender Gestalt test showed poor quality, lack of control, impulsivity, and perseveration.

CO-AUTHORS

NICHAMIN



BARAHAL

Doctor Nichamin is senior attending pediatrician at Children's Hospital of Michigan, Detroit; assistant clinical professor of pediatrics at Wayne State University Medical School, and in private practice of pediatrics. Doctor Barahal is professor of educational and clinical psychology at Wayne State University, psychological consultant to several school systems, and a member of the Michigan Commission of Certification of Psychologists.

Physical examination revealed normal growth and development for his age, with no organic basis for his overt hyperkinesis. Short attention span, inappropriate and irritating conduct, and excessive verbalization were prominent characteristics observed in the office. There were no relevant factors in the prenatal, natal, or perinatal histories; and the past medical history revealed no serious illnesses or accidents. Genetically, it was ascertained that his father had also exhibited a hyperkinetic profile.

Methylphenidate therapy was instituted. With the establishment of the appropriate dosage level, both parents and teachers reported an immediate complete reversal of the hyperkinetic pattern of behavior. He became amenable to ordinary school routines. His academic achievements were finally compatible with his superior IQ. Motor coordination, fine and gross, approached the normal. This was confirmed by actual samples of pre- and post-therapy written work. The family climate was then significantly altered beneficially. In this case, no further psychologic assistance or supportive tutoring was required.

2. M. A. MALE, AGED SIX, had evidenced a moderate degree of hyperactivity, restlessness, short attention span, with poor coordination, during the preschool years and continuing into kindergarten. It was our opinion that the hyperactivity would have been much more apparent during these years had the parents been more permissive. They had set strict limits for the child towards acting-out and unacceptable behavior; and had established considerable structuring in his management. However, in a normal kindergarten milieu, the abovementioned symptoms were triggered off and made more manifest. His physical growth and development from early infancy had been completely normal. There were no significant factors in the birth or past medical history.

On psychologic testing at the age of six years and two months, he scored as follows on the WISC: Verbal IQ 116, Performance IQ 111, and Full Scale IQ 115 (bright-normal range). The one significant drop in functioning occurred on the

Coding subtest where he manifested disturbed visual-motor-perceptual functioning. His Bender Gestalt reproductions were immature, with poor organization; and he revealed considerable difficulty with touching and overlapping parts and angulation. Ocular pursuit in reading was exceedingly poor, as evidenced by an inability to follow along a line or pursue a visual object. Reading and word-attack skills were non-existent, despite his high intelligence. His behavior throughout the testing suggested the presence of a perceptual disorder with faulty neurologic integration.

Soon after the dosage of methylphenidate was stabilized at 20 mg. daily, hyperactivity, distractibility, and restlessness were decreased markedly. The child now seemed amenable to the learning process.

Supportive reading tutoring was begun once weekly. School functioning improved dramatically. Achievement levels, as measured by the Metropolitan Achievement tests, revealed within less than a year, that he was performing above grade level. His current report card is completely confirmatory of his educational progress, with outstanding ratings in following directions: listening, respecting authority and property, and spelling. Parental attitudes have been transformed from frustration and anxiety into a more approving acceptance of their child and his progress. Their elation with this "new child" has been most rewarding, and has been reflected in a more wholesome, optimistic, and tension-free family climate.

3. D. H. WAS AN ADOPTED MALE CHILD who came under our health supervision at the age of nine and one-half months. There were no relevant factors in the medical or developmental histories. There had been parental preoccupation with bowel evacuation, as well as a multiplicity of minor complaints involving accidents or infections. These factors tended to obscure a basic hyperkinetic pattern that reached an acme at the age of three years. Marked distractibility, hyperkinesis, low frustration tolerance, and temper tantrums then became more apparent. Disciplinary techniques failed to alter the boy's unacceptable behavior. The parents sought relief from an intolerable, chaotic home atmosphere.

On the Stanford Binet Intelligence Scale the child achieved an IQ of 125, which placed him in a very superior category. His extremely immature behavior belied his high intelligence. He also revealed marked perceptual deficiencies, as evidenced in the perceptual-motor tasks. Both on the Binet and Winterhaven gestalts his performance was erratic and considerably below the expectations for his age group. Throughout the testing he manifested restlessness, hyperactivity, impulsivity, and an inability to cooperate. No additional tests were attempted because of his distractibility. He showed particularly strong capacities in verbal and abstract reasoning ability. His draw-a-person was inferior and immature. Copying of simple designs was totally inadequate. Performance on the mazes was replete with impulsiveness, poor judgment, and fine muscle incoordination.

After methylphenidate was introduced, a complete metamorphosis in the child's behavior occurred. Gloom and doom in the family environment were replaced by acceptance and serenity. At certain times the parents reported a brief spell of a peculiar lethargy and mild disorientation. Such incidents had been previously noted in a small percentage of our cases. Usually this aberrant reaction disappears upon a temporary (one week) withdrawal of the drug, followed by reinstitution at low levels of dosage, and then gradual increase to former levels with smaller increments than previously employed.

COMMENT

Emphasizing the use of methylphenidate in perceptual disorders need not be construed as a laissez-faire approach to all learning and behavioral deviations. Definitive pediatric and psychologic diagnosis of this entity of faulty neurologic integration is the sine qua non for effective results with it. Clear-cut evidence of the syndrome must be pinpointed through careful clinical observations and requisite psychologic testing.

There is no gainsaying that, at the very outset, a thorough physical and neurologic examination is the physician's responsibility, and recourse to specialized consultation (ophthalmologic, auditory, speech, EEG, etc.) is mandatory when indicated. In evaluating family histories, we have been strongly impressed with the predominance of genetic factors relating to this syndrome. Promiscuous use of this drug for a variety of school and behavior disorders, without a definitive diagnosis, would be shortsighted and inappropriate.

Early identification and diagnosis is possible, even at the pre-school level. A preventive program for private practice has been presented by one of us (S. J. N.).[5] In fact, federal financing has been approved for surveying this age group for potential perceptive and learning disabilities (Oak Park, Michigan, Board of Education). Early detection of the syndrome is also stressed by Boelsch.[6] During the preschool period, as well as in early infancy, awareness of the hyperkinetic syndrome can afford the opportunity of longitudinal observation and consequent earlier definitive diagnosis and drug administration. Such early drug therapy, with its consequential beneficial effect, can forestall serious ego damage to the child. Untreated, such a child would develop a depreciated self-concept and patterns of desperation and defeat. Likewise, a chaotic family ego disorganization can be ameliorated before cumulative damage is perpetuated. Intensive psychotherapy and miscellaneous lengthy perceptual-training exercises can be avoided.

The physician should carefully prescribe the drug dosage on an individual basis. The accompanying chart can serve as a useful guide, but gradual increases in dosage, up to twice the basic dose, may be necessary with growth or at times of stress. No change or improvement in the child's functioning or behavior is discernible until appropriate levels of dosage are attained.

Medication must be of a continuing nature and should not be omitted on weekends and vacation periods. The omission of even a single dose of the medication on a given day becomes readily apparent to the child himself, as well as to his parents and teachers. In some patients the effect of the drug given at noon is lessened or lost by late afternoon; parents then note a regression to former immature behavior patterns. The situation can be remedied by administering a small (2.5 mg. or 5.0 mg.) dose of the drug at such times.

SUMMARY

Based on our experience in private practice with more than 100 cases of faulty neurological integration with perceptual disorders, a two-dimensional, medical-psychological and pragmatic approach to therapy is presented, employing methylphenidate as the drug of the choice.

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Marked Eosinophilic Response to Combined Chlorpromazine and Trifluoperazine Therapy

BY MELVIN J. REINHART, M.D.
MARTHA STEPHENS, M.D.
ANN ARBOR

While it is generally known that mild to moderate eosinophilia can be representative of responses to allergens, be they dietary, inhalant, or drug, a review of the medical literature for the years 1960 through 1967 reveals only two reported cases of eosinophilia during therapy with psychotropic drugs. Joynt and Clancy report[1] in 1961 an eosinophil count of 61 percent in a patient receiving imipramine therapy with a total white blood cell count of 30,000. The blood elements rapidly returned to normal following a discontinuation of the medication. In 1964 Bacon[2] reported a case of leucocytosis with an eosinophilia of 41 percent during therapy with chlorpromazine, which likewise returned directly to normal upon discontinuation of the medication.

Our case represents, to the best of our knowledge, the first significant eosinophilic response to the combined chlorpromazine and trifluoperazine regimen which is so frequently used in treating psychotic patients.

CASE REPORT

The patient is a 40-year-old Caucasian female; a housewife who was hospitalized at the Neuropsychiatric Institute on November 17, 1967. She had expressed self-destructive and murderous thoughts toward family members prior to her admission.

The initial psychiatric examination revealed a moderate degree of agitation in a depressed woman. The other significant findings indicated she was probably experiencing auditory hallucinations. The physical examination revealed no particular physical abnormalities with the exception of a cystic enlargement of the left ovary felt to represent a functional ovarian cyst. The admission laboratory studies were all within essentially normal limits including a total white blood cell count of 8,400 with a differential cell count of 47 percent polymorphonuclear neutrophils, 45 percent lymphocytes, 8 percent monocytes, and zero percent eosinophils and basophils.

In order to treat her anxiety symptoms, she was begun on chlorpromazine, 200 mgs. per day on the day of her admission, (11-17-67) and this was increased by November 30, to 600 mgs. per day. On that date trihexyphenidyl hydrochloride, 2 mg. per day, was added to counteract extrapyramidal symptoms which were in evidence. Because the aforementioned drug regimen was inadequate to control the degree of agitation, trifluoperazine was added, 6 mgs. per day on December 6, concomitant with an increase in the trihexyphenidyl hydrochloride to 4 mgs. per day. From December 1, through 4, the patient complained of recurrent frontal headaches, which were relieved by Fiorinal and aspirin. A white blood cell count reported on December 4 was read as 13,700. On December 6 complaints of malaise, nausea, and weakness in the lower extremities were reported in addition to a single episode of emesis. The patient reported chills and diarrhea on December 7 with a temperature elevation to 100° orally noted. The white blood cell count reported on December 8, was 17,000 with a differential cell count of 58 percent polymorphonuclear neutrophils, 18 percent lymphocytes, 2 percent monocytes, 22 percent eosinophils and zero percent basophils. The repeated white blood cell count on December 11, was read as 25,100 and four days later on December 15,

GENERIC AND TRADE NAMES OF DRUGS

Chlorpromazine — Thorazine
Trifluoperazine — Stelazine
Trihexyphenidyl hydrochloride — Artane

Both authors are associated with the Neuropsychiatric Institute at the University of Michigan Hospital.

22,400 with a differential cell count of 15 percent polymorphonuclear neutrophils, 19 percent lymphocytes, 2 percent monocytes, 63 percent eosinophils and 1 percent basophils. The patient had been treated symptomatically with Kaopectate, paregoric, and tincture of belladonna to counteract her gastrointestinal symptoms. However, these symptoms did not respond to the antidiarrheal medication, bedrest, and liquid diet.

Upon receipt of the report of December 15 indicating a 63 percent eosinophilia with a white blood cell count of 22,400 the patient was transferred to the Internal Medicine Service with a suggestive diagnosis of parasite infestation. On December 16, the chlorpromazine had been decreased to 300 mgs. daily and on December 18 chlorpromazine, trifluoperazine, and trihexyphenidyl hydrochloride were discontinued. The total white blood cell count and eosinophil differential remained elevated with a total peripheral eosinophil count of 12,028-per-cubic milimeter. By December 21 the white blood cell count had further dropped to 12,100 with a differential cell count of 34 percent eosinophils. The patient's diarrhea had ceased by this time. The diagnostic studies completed on the Internal Medicine Service included a sigmoidoscopy with rectal biopsy, a barium enema, and numerous stool examinations, all of which were reported as being normal. An upper G.I. series revealed a small hiatus hernia. A bone marrow examination demonstrated an eosinophilia of 28 percent with mature cells. Chest film, hemoglobin, and hematocrit were normal. Electrophoresis manifested a slight elevation of total protein and alpha two globulin. Liver function studies always remained within normal limits. The patient was essentially asymptomatic from a physical point of view when she was transferred back to the Psychiatric Service on December 22, 1967. The total white blood cell count on December 27, 1967 was 8,000. The counts have remained essentially with-

TABLE 1

Composite of Serial Hemograms

Reported	Total W.B.C.	P.M.N.	Lymph	Mono	Eosin	Baso	Hgb grams	Hct	Alk. Phosphatase K.A. units	SGPT units
11/20/67	9,900						16.5	47	6 9	13
11/24/67	8,400	47	45	8	0	0	15.6	44	7.5	13
11/28/67	9,400									
12/ 4/67	13,700									
12/ 8/67	17,000	58	18	2	22	0	15.3	43.5		
12/11/67	25,100									
12/15/67	22,400	15	19	2	63	1				
12/18/67	26,000	26	13	3	58 12,028 (total eosin.)	0	16.3	48		
12/21/67	12,100	37	26	3	34					
12/27/67	8,000									
1/ 2/68	10,500									
1/ 5/68	11,300	59	28	10	3					
1/15/68	14,100								7.4	7
1/19/68	10,800	57	38	4	1					
1/22/68	8,700									
2/ 2/68	8,900	41	44	10	4					

in normal limits, subsequently, with the differential cell count repeated on three occasions within normal limits.

COMMENT

The above mentioned case was reported to highlight the possible association of eosinophilia with combined chlorpromazine and trifluoperazine therapy. Unfortunately, the implication of trifluoperazine is somewhat in doubt. One hemogram was completed two days after the initiation of trifluoperazine. At the time of its initiation, the white blood cell count had already been elevated on December 4, 1967 to 13,700. However, no differential cell count was done at that time. One could speculate that the eosinophilia had begun prior to the beginning of the trifluoperazine. However, in view of the relative infrequency of reported cases of eosinophilia with even chlorpromazine, the authors felt that this material should be called to the attention of the readers.

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Editorial Comment:

One wonders in view of the gastro intestinal symptoms what a trichmilla skin test might have shown.

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Michigan Department of Corrections Explains School - Pass Program

The Michigan Department of Corrections has inaugurated a new program in correctional education in this state which you should know about because of your interest in civic matters.

This new program is called a "Study-Pass Program" and offers to carefully selected and qualified inmates of Michigan prisons, an opportunity for advanced technical or academic training by attending classes on the campus of nearby community colleges or state universities.

Chief purposes are to help these men test their ability to do acceptable college-level work and to assist them in making a beginning on a college course so that their training is more apt to continue when they return to the communities. In addition, the program opens up opportunities for special or advanced training which are not available at the correctional facilities.

THE BASIC RATIONALE for this new program involves the following:

1. Many men in prison have special aptitudes and skills for which there are no institutional programs because these are too expensive to equip and staff. These programs do exist in the community and it seems practical and wise to take these men to them.
2. There are many men in the prison population who have both the intellectual ability, the interest and the academic background for college-level work. Most of them have not been aware of this and, therefore, have not thought seriously about the possibilities of attending college. They represent a sizable, untapped, human potential which should be made available to society.
3. The Federal system and one or two other states have experimented successfully with this type of a venture and their experience has been used as a foundation.
4. Successful experiences of this kind should do a great deal to improve the image that these men have of themselves and help them to see themselves as more worthy persons.

THE DETAILS OF the plan are:

1. The participants are carefully screened for evidence of intellectual, academic or technical aptitude and a sincerity of interest in the training available.
2. Only those men who are fairly close to release on parole and who do not constitute in any way a menace to the students at the college or to the community generally, would be approved.
3. The participants must have demonstrated dependability and responsibility which would merit their enrollment in this kind of a program.
4. They are transported from the institution each morning to the campus where they are on their own like any other student during the day and are picked up in the late afternoon and returned to the institution.
5. They are required to follow all the college regulations which apply to the other students and, in addition, have certain understandable restrictions on their activities from the standpoint of the Department of Corrections.
6. College credits earned are available for transfer to other colleges and universities where the student may wish to continue in his work when released from the institution.

Financing is taken care of in several different ways. First, if the student or his family have sufficient financial resources he pays his own way. Second, some are eligible for assistance from the Division of Vocational Rehabilitation or under the GI Education Benefits. Third, a modest Tuition Loan Fund has been established by the Department through donations and gifts from interested citizens and is available for men who have no other resources. They draw from this fund on a loan without interest and repay from their income after release.

At the present time, the following colleges are cooperating in the program and have students on the campus: Montcalm Community College, Jackson Community College, Lansing Community College, and Northern Michigan University.

Those men presently engaged in this program have demonstrated college ability and represent a very important human resource in this state which might otherwise be wasted. ☐

A Case History:
The Payoff Is Rehabilitation

BY C. ARTHUR HAKENEN, CHIEF,
DISABILITY DETERMINATION SERVICE
DIVISION OF VOCATIONAL REHABILITATION
STATE DEPARTMENT OF EDUCATION

Much has been written and said about vocational rehabilitation programs. One of the primary areas of concern is that of the costs involved.

That the costs of such programs can, in some instances, be the least expensive way out for the taxpayer can best be understood with a specific example.

A neurologist's report in July of 1959 had this to say about Mr. H., age 37, after his cerebral vascular accident.

CASE HISTORY

"Spinal puncture revealed bloody xanthochromic fluid indicative of preceding subarachnoid hemorrhage. Bilateral carotid angiography showed a small vestigial aneurysm at the intracranial bifurcation of the carotid on the right and a very large bilobular aneurysm at the same location on the left with some evidence of hemorrhage into the left frontal lobe. . . .

"This patient has made a good immediate recovery from his very serious condition, but I am afraid that the partial ligation of the carotid is, unfortunately, no safe guarantee against further blow-outs; besides, the hemorrhage had been severe enough to cause considerable neurological deficit, which may not clear up completely in the future. For these reasons, I believe that this patient will unfortunately not be able to return to his former job and his outlook as to the future must remain quite guarded."

In April, 1960 checkup at the medical center showed residual mild sensory-motor deficit in the right-sided extremities and marked dysphasia. Prognosis remained guarded.

IT WAS A BLEAK picture for Mr. H., his wife and their four small children. Before the CVA he had been plant superintendent of the tool factory in a small town. Returning to this demanding management position was impossible, because of his frustrating inability to communicate; there was nothing else for which he qualified in his present status. In due course he filed for Social Security disability benefits and his case was evaluated by the Disability Determination Service of the Michigan Division of Vocational Rehabilitation. Mr. H. and his family were found eligible for a grant of $254 a month.

But the Review Physician and the Disability Examiner who adjudicated this claim did not stop there. They also considered Mr. H.'s rehabilitation potential — could he be helped by speech therapy, for example? They decided to refer him to the Vocational Rehabilitation office in his area for evaluation. The new plant superintendent also sought out the VR Counselor, to enlist his help in getting this valued employee back to work, in a job within his capacities.

Mr. H. had something in his favor: He was strongly motivated, although intermittently depressed by the CVA residuals which had diminished his value in the labor market; he had the understanding support of his wife and her interest in the rehabilitation plan.

Although the dysphasia was a formidable barrier, the VR Counselor was encouraged by the current psychological and neurological evaluations and arranged speech training at the medical center. Subsistence expense while in training was shared by the employer through his insurance coverage, the agency and the family.

DURING THIS two-and-a-half-year training period, the Counselor had many conferences with plant officials to discuss progress and employment prospects. In December, 1961 the Counselor asked the company for two sets of the pneumatic hand tool it manufactured — one completely assembled, made up of 41 small parts and the housing — and the other unassembled. He took the two sets to the occupational therapist at the medical center; between them they worked out a plan for Mr. H. to practice assembling the tool, just as it was done on the company assembly line.

Mr. H. worked hard on his speech training and tool assembly and in October, 1962 the Counselor suggested a two-week tryout in the plant. The test was successful and Mr. H. returned to work on a full-time basis as an assembler at $80 a week. He was given a twelve-month trial work period (the maximum), to test his ability to work without loss of benefits — an incentive built into the program to encourage rehabilitation. The benefits stopped in October, 1963.

The Counselor and I visited Mr. H. at his home — he was on vacation — in May, 1968 and found he was still working as assembler and happy with it. He has had several pay increases. Mr. H. still has some difficulty with writing, especially the small words; when he speaks, he has to reach occasionally for the right word. His wife, a registered nurse, told us he had made a good adjustment to working in a lesser capacity. The aneurysm on the right is still there, encased in scar tissue, but he has had no medical problems and gets a checkup every year.

WE STOPPED AT THE factory and visited with the plant superintendent and the foreman. Mr. H. has an excellent production record, we were told, and is considered a superior employee. Because of his management know-how before the CVA they would like to give him more responsibility and discussed this prospect with Mrs. H. She prefers to wait until he is ready for it.

The total cost for VR services provided came to $2,248. Now, let's take a look at the return from this investment in rehabilitation: Had Mr. H. remained idle he would have continued to draw benefits from the Social Security trust fund — $14,732 from October, 1963 through July, 1968. Actually, the amount would be considerably higher because of several increases in cash benefits enacted by Congress. In addition to this substantial saving to the trust fund Mr. H. became a self-supporting taxpayer again, and what this meant to him and his family cannot be measured.

SOCIAL SECURITY TRUST FUNDS

A 1965 Social Security amendment makes money available from Social Security trust funds to finance the rehabilitation of selected beneficiaries — those with the potential to return to productive work through VR services. The amount so released each year to the State Agencies may not exceed one per cent of the total amount paid nationally in disability benefits the previous fiscal year. For the year ending in June, 1968 Michigan received $484,224 in trust fund money.

During this period these Social Security funds made it possible for our agency to rehabilitate 362 beneficiaries, who might not have been served otherwise because of state budget limitations. The average cost for each rehabilitation was $1,108; if we use the national average for payments to each beneficiary and his dependents — $175 a month — Social Security will get back its money in less than a year of employment. We also have 1,051 clients on our active caseload, whose rehabilitation is in process.

THE JOBS OUR CLIENTS entered into were a cross section of Michigan occupations, unskilled to highly technical. Their weekly pay ranged from $40 (cafeteria helper) to $150 (automatic valve grinder). Rehabilitation services included counseling, medical treatment to correct or reduce the disability, prostheses, vocational training at various levels and job placement help.

There will be more trust fund money available for rehabilitation in the future. In Michigan, for example, the disability payments total in February, 1968 was running $6,845,447 a month; this was going to 45,063 disabled workers, their 7,405 spouses and 24,991 children. While this represents substantial buying power, a regular paycheck will bring in more for those with rehabilitation potential. The Social Security-Vocational Rehabilitation partnership wants to help more people get back to work. Rehabilitation costs money, but it pays. ☐

William M. LeFevre, M.D., Muskegon, has retired from 43 years of private practice in Muskegon to become plant physician at DuPont in Montague. For 10 years a councilor of the MSMS 11th District, Doctor LeFevre continues active in MSMS, serving as chairman of the MSMS Diabetes Committee, member of the MSMS Beaumont Memorial Committee, and advisor to the Committee on History. He is known to many as the first president of the Michigan Association of the Professions, past president of Michigan Diabetes Association, and past president of the Muskegon County Medical Society.

Wesley G. Logan, M.D., Hastings, has been appointed to the 10-member vocational service consultative group of Rotary International. He has served as a past president of the Rotary Club of Hastings and as a district governor of Rotary International. He is an alternate delegate from the Barry County Medical Society to the MSMS House of Delegates, a past president of the Barry County Medical Society, and chief of staff at Pennoch Hospital, Hastings.

C. A. Dickinson, M.D., Wayland, a past president of the Allegan County Medical Society, has ended 35 years of private practice to become medical director of the Allegan County Health Department. He has served as coronor and medical examiner since 1935.

Robert E. Bogue, M.D., Detroit, is currently president of the Michigan Society of Obstetrics and Gynecologists. President-elect of the Society is Joseph B. Woolfenden, M.D., Grosse Pointe. Serving as treasurer is John M. Malone, M.D., Detroit, and as secretary, Joseph J. Woods, M.D., Ypsilanti.

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Michigan
State
Medical
Society

Hilliard Jason, M.D., East Lansing, discussed the educational philosophy and curriculum innovations of the Michigan State University College of Human Medicine in Helsinki, Finland, at the meeting of the 17th General Assembly of the International Federation of Medical Student Associations. Doctor Jason is director of MSU's Office of Medical Education Research and Development.

James G. Christopher, M.D., Hamtramck, has retired from his post of chief pathologist of Holy Cross Hospital, Hamtramck. He had been associated with the hospital since it opened in 1946. At different times, Doctor Christopher has been a member of the medical faculty at the University of Vienna, Wayne State University, and the University of Detroit Dental School.

Kenneth E. Pitts, M.D., Grosse Pointe, associate professor of psychiatry at the Wayne State University School of Medicine, is supervising a graduate training program in psychiatry, to be continued through a recent grant of $71,623 from the Public Health Service.

Allen B. Moore, M.D., Essexville, has accepted a position as assistant medical director of the International Harvester Company, Chicago. He resigned from the Saginaw Valley College Board of Control to which he had been appointed by Governor Romney.

Samuel T. Sandell, M.D., Houghton, was feted at a retirement dinner by his colleagues of the Houghton, Keweenaw and Baraga County Medical Society. Former head of the Copper Country Tuberculosis Sanitorium of Houghton and Hancock, he will retire in Duluth.

Norman Harebottle, M.D., Fowlerville, and family were bade farewell at an open house given by the Lutheran, Baptist, Catholic and Methodist ladies societies of Fowlerville. After 10 years in the community, the family is moving to Tempe, Arizona. Doctor Harebottle is a former president of the Livingston County Medical Society.

Robert E. O'Connor, M.D., Detroit, has been appointed to the newly-created position of Director of Clinical Development for Parke, Davis and Company. Doctor O'Connor, who will review and evaluate plans and clinical studies for new drugs and explore new applications for marketed products, joined Parke-Davis in 1963 after practicing in California. He obtained his M.D. from the University of Illinois.

Community Health Week, October 20-26

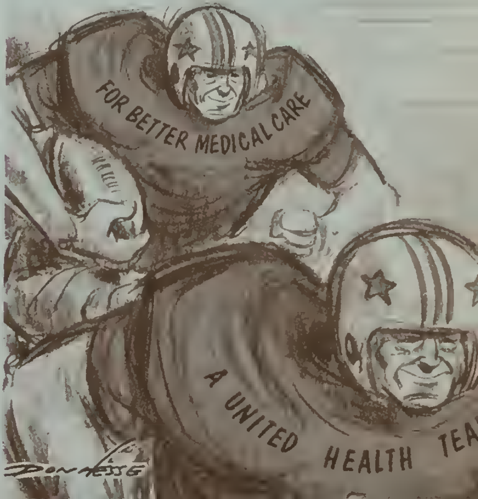
Every county medical society in Michigan is urged to develop appropriate programs marking the annual observance of Community Health Week, October 20-26 and to encourage other members of the community health team to join with them in planning and carrying out activities.

The purpose of Community Health Week (October 20-26) will be to focus public attention on the dramatic advances which have occurred in medicine and health care. The Annual Community Health Week project is proclaimed by the AMA and MSMS to stimulate a greater public understanding of the growth, high quality and availability of health resources and facilities within the individual community.

The 1968 Community Health Week this fall will focus attention upon (1) the growing problem of drug abuse, (2) the need to encourage and support the programs encompassing physical fitness, and (3) the expanding, urgent need for young men and women to train for medical and allied health careers.

Each county society has been urged to organize a health careers recruitment program. Doctors can speak to school assemblies, can consult with school counselors, can cooperate with the medical auxiliary and voluntary agencies, etc.

As in other years, the Michigan Health Council and the Michigan Association of the Professions will jointly sponsor Community Health Week with MSMS.



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MSMS-MHC to Sponsor Careers Workshop Oct. 23

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A special health careers conference will be held October 23 near Battle Creek for representatives of county medical societies, hospital board members, hospital administrators, school counselors, community college officials, county supervisors, nurses, and all others interested in health manpower.

The theme will be "Health Manpower Is a Community Affair."

The one-day meeting will be held at the pleasant Michigan Education Association Conference Center on St. Mary's Lake. The MSMS Committee on Rural Medical Service and the Michigan Health Council will sponsor the workshop. Robert E. Rice, M.D., Greenville, the program chairman for the event, is chairman of both the MSMS Committee on Rural Medical Service and the MHC Professional Placement Committee. Major speaker will be Milford O. Rouse, M.D., Texas, past-president of the AMA.

The agenda will cover the following topics:

Health Manpower
Role of the Community College
Role of the University
Role of the Community Hospital in health care programs
Progress report on MHC manpower study in Southwestern Michigan
Role of Voluntary Health Councils

All interested MSMS members are invited to attend, and a special appeal has been made to every county medical society president to send several representatives.

The conference will be one of several Community Health Week features.

Hearing-Speech Conclave Soon

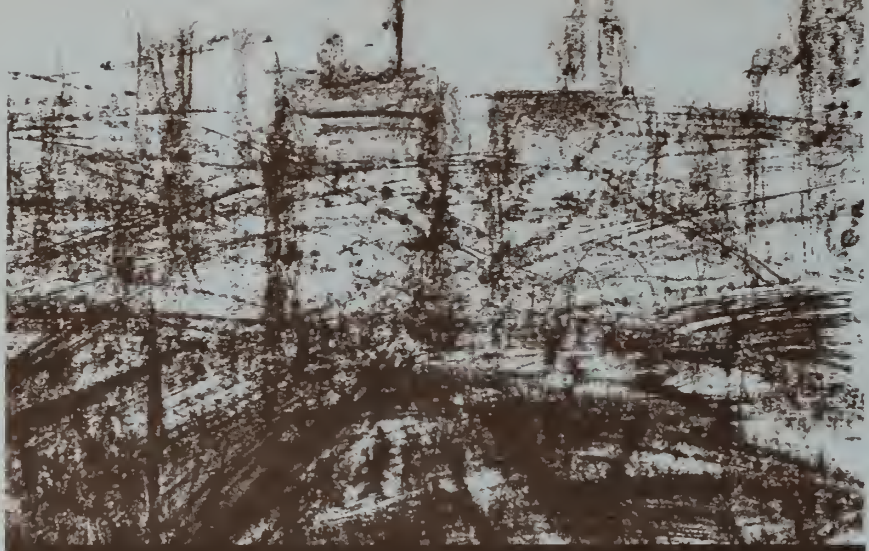
Medical personnel interested in ear problems and those working with very young children will want to clear their calendars for Friday, September 27.

Marion P. Downs, director of clinical audiology at the University of Colorado Medical Center, Denver, will speak on "Identification of Hearing Impaired Infants" to open the Michigan Association of Better Hearing and Speech convention at the Pick-Fort Shelby Hotel, Detroit.

Mrs. Downs, an instructor in surgery in the University's otolaryngology division, is a consultant to the ENT department at Fitzsimons Army Hospital.

Theme of the convention will be "Early Identification and Habilitation of Hearing Impaired Children."

Royal C. Hayden, Jr., M.D., Detroit area otologist and director of the Otological Research Laboratory at Henry Ford Hospital, will be Friday chairman.



Urge Every MSMS Member Attend September 25-26

House to Install Lightbody, Pick Other Leaders

The election of the MSMS president-elect will be one of the highlights at the House of Delegates meeting in Sheraton-Cadillac Hotel, Detroit, September 22-25. The elections will be Tuesday night, September 24.

Four Delegate and Alternate Delegate posts to the AMA will also expire and be open for election. Current incumbents in these positions are: Delegate — Sidney Adler, M.D., Detroit; George W. Slagle, M.D., Battle Creek; Donald N. Sweeny, Jr., M.D., Detroit; Joseph A. Witter, M.D., Highland Park; Alternate Delegate — James C. Danforth, Jr., M.D., Detroit; John J. Coury, M.D., Port Huron; Marjorie Peebles-Meyers, M.D., Detroit; and Vernon V. Bass, M.D., Saginaw.

Terms of office for MSMS Councillors Milton R. Weed, M.D., Grosse Pointe Park (1st District), John J. Coury, M.D., Port Huron (7th District), A. Carl Stander, M.D., Saginaw (8th District), Edward H. Rodda, M.D., Bay City (10th District), Eugene R. Elzinga, M.D., Marquette (12th District), and Robert J. Mason, M.D., Birmingham (15th District) will expire this year.

Elections also will be held for the speaker and vice-speaker of the House of Delegates.

James J. Lightbody, M.D., will be installed as new president of MSMS at a delegate dinner meeting in the Book Casino.

The elections will cap three days of work by the House of Delegates, beginning on Sunday, September 22, at 6 p.m. with reference committee chairmen gathering for the Speaker's Dinner.

The Speaker's Dinner will be followed by the first meeting of the House of Delegates. Gerald D. Dorman, M.D., AMA President-Elect, will bring greetings to the delegates. Also speaking at that time will be MSMS President Bradley M. Harris, M.D., and President-Elect James J. Lightbody, M.D.

Other highlights of the first meeting of the House will be the report of the committees on Certificates of Commendation and Michigan's Outstanding Physician.

Delegates will consider resolutions and reports Monday and Tuesday. The Fifty Year Awards will be given Tuesday.

Sheraton-Cadillac Lifting Its Face

The Sheraton-Cadillac Hotel, looking forward to the MSMS Annual Session and other fall conventions, has just completed the first stage of a $4,000,000 renovation and improvement program.

Four hundred guest rooms and suites have been redecorated and refurnished, with plans to complete the remaining 800 rooms in the next year.

One million has been spent already for new, high-speed automatic elevators.

The hotel is currently in the process of replacing all windows on the first six floors, and eventually, throughout the hotel.

Tentative plans for a $8,500,000 addition to the hotel are being developed by Mark Schmidt, vice president and general manager. A 17-story addition will be built adjoining the present hotel, replacing the Detroit Edison building on Washington Boulevard and the Hughes-Hatcher-Suffrin store on Shelby at State. The addition will have 300 guest rooms, a swimming pool, restaurant, and fashionable shops on the ground level. There will also be an underground garage for 350 cars. The ballroom will be expanded to accommodate 1,500 persons.

BEGIN WORK SOON ON UPJOHN CENTER AT ANN ARBOR

Work is to begin shortly on the nation's first university-based research and training center devoted to clinical pharmacology.

University of Michigan officials signed papers this week awarding the $988,714 construction job on the Upjohn Center to Jeffress-Dyer, Inc., of Ann Arbor.

The Upjohn Center was made possible by a gift of $1.1 million from the Upjohn Company.

Cross-Shield Get Okay for New Building

The Detroit Common Council on August 27 approved plans submitted by Michigan Blue Cross and Michigan Blue Shield to purchase property for a new combined service center to be erected on an 11.6-acre downtown urban renewal site north of Jefferson and west of the Chrysler Freeway.

The Detroit City Housing Commission previously approved the transfer of the land and the Detroit Planning Board approved the building plans.

THE CENTER WILL consist of a 22-story administration building and a connecting three-story computer facility costing an estimated $27.5 million.

A five-deck parking garage for 1,262 automobiles which is required under city planning commission zoning regulations also will be built. The garage will cost approximately $2.9 million and will be paid for through parking fees.

Other costs include $1,203,339 for the land, plus site preparation work and architect fees. The complex has been designed by Giffels and Rossetti, Inc.

The computer facility is expected to be completed by April, 1970, and the administration building completed by December, 1970.

Project costs will be shared equally by Blue Shield and Blue Cross.

IN A JOINT STATEMENT, William S. McNary, president of Michigan Blue Cross, and John C. McCabe, president of Michigan Blue Shield, said that a substantial part of the financing will be through mortgage.

"The building program is designed for efficiency and functionalism," McNary and McCabe added. "It has no frills and it does not require any increase in rates.

"The decision was based on a 10-month study by outside consultants which showed that increasing operational difficulties would result from further scattering of operations to meet the growth in our business.

"The study indicated that it is costing Cross and Shield an extra $100,000 a month to do business from fragmented and rental locations.

"The study showed that it would cost us $4.50 a square foot to build as opposed to our present rental costs of $5.57 a square foot.

"We are therefore building to save money as well as building to centralize our operations and improve service to our subscribers and providers of service."

The corporations currently rent more space than they own.

The facilities will include a 300-seat auditorium, to be available for public and professional groups concerned with health care. The site has enough land for an additional building in the future.

Detroit Mayor Cavanagh described the proposed center as a "major step in Detroit's revitalization," and added: "The new Blue Cross - Blue Shield center is a very sizeable addition to downtown Detroit's area redevelopment. It will mean more jobs for Detroiters as the needs for medical-hospital programs increase."

The new Michigan Blue Cross and Blue Shield combined service center will look like this architect's model. At left is the five-level parking garage, with the administration building in the center, at the corner of St. Antoine and Lafayette East. The computer facility, with separate humidity and air cleaning and conditioning controls required by its electronic equipment, is at the right.

Internists Confer Soon at Gaylord

Specialists in internal medicine in Michigan will hold a scientific meeting in Gaylord, September 20-21, under the auspices of the American College of Physicians (ACP).

Special guest at the meeting will be H. Marvin Pollard, M.D., ACP President, and professor of internal medicine at the University of Michigan Medical School.

The meeting at the Otsego Ski Club is under the general direction of Muir Clapper, M.D., Detroit, ACP Governor for Michigan and Professor of Medicine, Wayne University College of Medicine.

PAC Breakfast Sept. 25 Offers Conyers, Riegle

MDPAC will hold a congressional breakfast featuring talks by Congressman John Conyers Jr., (D), Detroit, and Donald W. Riegle Jr., (R) Flint, on September 25 at the Sheraton-Cadillac Hotel during the MSMS Annual Session.

Breakfast chairman is George L. Reno, M.D., of Detroit. Assisting him are John Moses, M.D., Wyman C. C. Cole Jr., M.D., Sidney Chapin, M.D., Vernon V. Bass, M.D., and Lionel Swann, M.D.

A special guest at the breakfast will be Mrs. Frank Gastineau, an AMPAC board member from Indianapolis. Tickets for the breakfast, available from MSMS headquarters, are $4.50.

"Ars Medica" Highlight for Annual Session

Throughout the Scientific Session, *Ars Medica*, an exhibition of prints depicting medical subjects, will be on special display at the Detroit Institute of Arts. The collection comes from the Philadelphia Museum of Art, where it is on permanent display.

Established through the generosity of Smith, Kline & French Laboratories, the collection will be on display from September 22 to October 20.

Arrangements were made by the Department of Graphic Arts at the Institute and a committee of Detroit physicians who raised the necessary money for shipping the display.

Oakland University Series on Hormones Open to Physicians

The Third Post Graduate Professional Education Symposium Series sponsored by Oakland University for area physicians will begin Sept. 17.

The series of programs is designed to furnish interns, residents and practicing physicians basic information on hormones and their action along with new knowledge on recent developments in the important field of endocrinology and clinical applications of this knowledge in selected areas of medical practice. All sessions are scheduled 7:30 to 9:30 p.m. in Room 195 of the Science Building.

The first session, Tuesday, Sept. 17, is entitled "How Hormones are Made" by Piero P. Foa, M.D., WSU.

The second session, Tuesday, Oct. 1, "How and Where Hormones Work" is also by Dr. Foa.

On Tuesday Oct. 15, the third session will be held. "New Concepts of Diabetes" is the topic for George C. Gerritsen, Ph.D., The Upjohn Co.

The fourth session will be Tuesday Oct. 29, with William L. Miller, Ph.D. of The Upjohn Co. His subject is "Insulin and Oral Agents."

Session five will be Tuesday, Nov. 12. "Hormonally Active Non-Endocrine Tumors" is the subject for Lawrence Power, M.D., WSU.

"Newer Aspects of Reproductive Physiology" will be the subject for Earl Plunkett, M.D., U. Western Ontario, on Tuesday Nov. 26.

The final session, Tuesday Dec. 10, will be "The Pill and Its Problems" by S. J. Behrman, M.D., U. of M.

NAMED AT SAGINAW

Robert Clowater, M.D., has become the medical superintendent of the Saginaw County Hospital, succeeding retiring superintendent V. K. Volk, M.D. Doctor Clowater was succeeded in his former position as medical superintendent of Muskegon Northshore Hospital by W. Leonard Howard, M.D.

Michigan Men Hear Ideas at PR Seminar

Medicine today faces the task of relating medicine to matters of public concerns, declared AMA President Dwight L. Wilbur, M.D., at the 1968 AMA Public Relations Institute, attended by MSMS leaders in Chicago late in August.

MSMS President B. M. Harris, M.D., MSMS PR Chairman Brock E. Brush, M.D., and Scientific Editor John W. Moses, M.D., led the Michigan physicians and MSMS staff members at the workshop.

Many of the current MSMS projects were displayed in the exhibit room of tested public relations ideas.

In discussing advances in medical sciences and growing government involvement in health care, AMA President Wilbur suggested that the medical profession must focus attention on quality of care and also should become more concerned about the delivery of such care.

There were many speakers — and some urged county medical societies to re-evaluate their functions. It was suggested that county societies "must pause to see where we have been, where we are today, and where we go from here."

MARMP HELPS BEGIN DRUG INFO CENTER

A Drug Information Center has been established at the University of Michigan under a grant from the Michigan Association for Regional Medical Programs, Inc., to act as a rapid, random access, service function to the medical professions of the State. Its goal is to help bridge the gap between the medical professions and the estimated 200,000 articles of medical interest published per year.

MSMS Delegates & Alternates For 1968 MSMS House of Delegates

OFFICERS

Speaker:
James B. Blodgett, M.D., 76 W. Adams, Detroit 48226

Vice Speaker:
Vernon V. Bass, M.D., 3322 Davenport, Saginaw 48602

Immediate Past President:
C. Allen Payne, M.D., 1840 Wealthy Street, Grand Rapids 49506

Secretary:
Kenneth H. Johnson, M.D., 1116 Michigan National Tower, Lansing 48933

ALLEGAN

Gerald A. Vander Voord, M.D., 312 E. Plum, Wayland 49348
James I. Clark, M.D., Box B, Fennville 49408

ALPENA-ALCONA-PRESQUE ISLE

Frederick C. O'Dell, M.D., 615 W. Chisholm, Alpena 49707
Edward A. Hier, M.D., 125 N. Second, Alpena 49707

BARRY

Robert J. Huebner, M.D., 110 W. Center, Hastings 49058
Wesley G. Logan, M.D., City Bank Building, Hastings 49058

BAY-ARENAC-IOSCO

Howard T. Knoblock, M.D., 1102 Columbus, Bay City 48706
Robert C. Prophater, M.D., 202 Boehringer Court, Bay City 48706
William G. Gamble, M.D., 2010 5th Avenue, Bay City 48706
Jiri Josef Bozdech, M.D., 900 N. Jackson, Bay City 48706

BERRIEN

F. Alan Kennedy, M.D., 315 Fidelity Bldg., Benton Harbor 49022
Frederick H. Lindenfeld, M.D., 8 N. St. Joseph St., Niles 49120
Noel J. Hershey, M.D., P.O. Box 222, Niles 49120
John H. Carter, M.D., 687 E. Empire Ave., Benton Harbor 49022

BRANCH

Robert M. Leitch, M.D., 401 Ann St., Union City 49094
John J. Rick, M.D., 61 E. Chicago St., Coldwater 49036

CALHOUN

Russell C. Rowan, M.D., 500 S. Ionia, Albion 49224
George R. Kelleher, M.D., 235 North Avenue, Battle Creek 49017
Alfred G. McCuaig, M.D., 719 Capitol Ave., S.W., Battle Creek 49015
Salvatore A. Yannitelli, M.D., 710 North Avenue, Battle Creek 49017

CASS

Henry V. Guzzo, M.D., 515 Main St., Suite 1, Dowagiac 49047
Kenneth C. Pierce, M.D., 417 W. High, Dowagiac 49047

CHIPPEWA-MACKINAC

Donald D. Finlayson, M.D., 301 E. Spruce, Sault Ste. Marie 49783
William F. Mertaugh, M.D., 104 W. Spruce, Sault Ste. Marie 49783

CLINTON

James M. Grost, M.D., Park Avenue, St. Johns 48879
Franklin W. Smith, M.D., 205 W. State, St. Johns 48879

DELTA-SCHOOLCRAFT

Donald N. Fitch, M.D., Doctors Park, Escanaba 49829
M. E. Wehner, M.D., 131 River St., Manistique 49854

DICKINSON-IRON

Donald T. Anderson, M.D., 408 Hamilton Ave., Kingsford 49801
Richard D. Cecconi, M.D., Commercial Bank Bldg., Iron Mountain 49801

EATON

Clayton O. Willits, M.D., 127 Upland, Charlotte 48813
Bryon P. Brown, M.D., 541 Lansing St., Apt. 2, Charlotte 48813

GENESEE

Clifford W. Colwell, M.D., 328 S. Saginaw, Flint 48502
Ernest P. Griffin, Jr., M.D., 503 S. Saginaw, Flint 48502
Franklin W. Baske, M.D., 923 Maxine St., Flint 48503
Lewis E. Simoni, M.D., 3210 S. Dort Hwy., Flint 48507
Philip K. Stevens, M.D., 1116 Mott Fdtn. Bldg., Flint 48502
Charles A. Thompson, M.D., 4211 Comstock, Flint 48504
Lawrence G. Bateman, M.D., 1928 Lewis, Flint 48506
John Quin, Jr., M.D., 2765 Flushing Rd., Flint 48504
Robert M. Weber, M.D., 420 S. Ballenger, Flint 48504
Richard J. McMurray, M.D., 2765 Flushing Rd., Flint 48504
Paul E. Schroeder, M.D., 1673 N. Chevrolet, Flint 48504
John C. Benson, M.D., 639 Mott Fdtn. Bldg., Flint 48502
John W. MacKenzie, Jr., M.D., 4437 Morrish Rd., Swartz Creek 48473
Vernon C. Urich, M.D., 3169 W. Pierson Rd., Flint 48504

GOGEBIC

Rex R. Harrington, M.D., 104 E. Ridge, Ironwood 49938
Bela Gallo, M.D., Newport Clinic, Ironwood 49938

GRAND TRAVERSE-LEELANAU-BENZIE

Frank H. Power, M.D., 116 Cass, Traverse City 49684
Donald G. Pike, M.D., 1105 E. Front St., Traverse City 49684
Richard L. Thirlby, M.D., 228 S. Madison, Traverse City 49684
Arthur F. Dundon, M.D., 1100 Sixth St., Traverse City 49684

GRATIOT-ISABELLA-CLARE

John M. Wood, M.D., 1108 S. Watson, Mt. Pleasant 48858
Jack M. Stack, M.D., 310 Warwick, Alma 48801

HILLSDALE

Clark B. Smith, M.D., 252 S. Howell, Hillsdale 49242
William B. Davis, M.D., 55 Barry, Hillsdale 49242

HOUGHTON-BARAGA-KEWEENAW

Samuel T. Sandell, M.D., 305 Vivian, Hancock 49931
John A. Strouble, M.D., 522 W. Third, L'Anse 49946

HURON

Charles W. Oakes, Jr., M.D., 7890 Sand Beach, Harbor Beach 48441

Kenneth B. Herrington, M.D., 317 S. Port Crescent, Bad Axe 48413

INGHAM

Robert M. Stow, M.D., 2909 E. Grand River, Lansing 48912
D. Bonta Hiscoe, M.D., 2909 E. Grand River, Lansing 48912
Herbert W. Harris, M.D., 919 Chester Road, Lansing 48912
Justin L. Sleight, M.D., 2909 E. Grand River, Lansing 48912
Charles O. Long, Jr., M.D., 2909 E. Grand River, Lansing 48912
Norman D. Henderson, M.D., 726 Abbott Road, East Lansing 48823
David Siegel, M.D., 2909 E. Grand River, Lansing 48912
Joseph R. Cipparone, M.D., St. Lawrence Hospital, Lansing 48914
Richard C. Bates, M.D., 2909 E. Grand River, Lansing 48912
John G. Wiegenstein, M.D., St. Lawrence Hospital, Lansing 48914

IONIA-MONTCALM

Robert E. Rice, M.D., 420 S. Bower St., Greenville 48838

JACKSON

Harold L. Oster, M.D., 1514 Fourth, Jackson 49203
Francis P. McQuillan, M.D., 611 Center, Jackson 49202
Edward R. Weddon, M.D., R.F.D. #2, Stockbridge 49285
Duane M. Allen, M.D., Hanover Medical Center, Hanover 49214

KALAMAZOO

William D. Harrelson, M.D., 1324 S. Park, Kalamazoo 49001
A. John Neerken, M.D., 404 Bronson Medical Ctr., Kalamazoo 49001
Thomas E. Andres, M.D., 1634 Gull Road, Kalamazoo 49001
W. Kaye Locklin, M.D., 1141 S. Rose, Kalamazoo 49001
Franklin H. Cox, M.D., Borgess Hospital, Kalamazoo 49001
Russell M. Cashen, M.D., 403 Bronson Medical Ctr., Kalamazoo 49001
Robert R. Dew, M.D., 1711 Merrill, Kalamazoo 49001
George J. Hoekstra, M.D., 100 Maple, Parchment 49004

KENT

Noyes L. Avery, M.D., 515 Lakeside Drive, SE, Grand Rapids 49506
Fred C. Brace, M.D., 1498 Lake Drive, SE, Grand Rapids 49506
Frederick S. Gillett, M.D., 50 College Ave., SE, Grand Rapids 49503
William Haeck, Jr., M.D., 245 State St., SE, Grand Rapids 49502
Kornelius Van Goor, M.D., 26 Sheldon Ave., SE, Grand Rapids 49502
Harvey M. Andre, M.D., 500 Cherry St., SE, Grand Rapids 49503
Jack Hoogerhyde, M.D., 26 Sheldon Ave., SE, Grand Rapids 49502
Victor A. Notier, M.D., 50 College Ave., SE, Grand Rapids 49503
Jack G. Lukens, M.D., 245 State St., SE, Grand Rapids 49502
Carl H. Moberg, M.D., 833 Lake Drive, SE, Grand Rapids 49506
John C. Montgomery, M.D., 1810 Wealthy St., SE, Grand Rapids 49506
Joseph R. Lentini, M.D., 303 Fulton St., E, Grand Rapids 49502
William E. Kincaid, M.D., 100 Michigan, NE, Grand Rapid 49503
Robert J. Raiman, M.D., 50 College Ave., S.E., Grand Rapids 49503
Richard A. Rasmussen, M.D., 1810 Wealthy, SE, Grand Rapids 49506
Robert D. Burton, M.D., 515 Lakeside, SE, Grand Rapids 49506

LAPEER

Charles E. Conaway, M.D., 1257 N. Main, Lapeer 48446
Leon R. Boruch, M.D., 834 Liberty, Lapeer 48446

LENAWEE

Donato F. Sarapo, M.D., Mill Street, Adrian 49221
Eleanor P. Skufis, M.D., 201 Orchard Rd., Adrian 49221

LIVINGSTON

Edwin S. Woodworth, M.D., 1200 Byron Rd., Howell 48843
Robert T. Polack, M.D., 1225 Lakeside Dr., Howell 48843

LUCE

Bernard G. Keizer, M.D., Newberry State Hospital, Newberry 49868

MACOMB

Peter V. Kane, M.D., 67 Cass Avenue, Mt. Clemens 48043
Charles M. Ebner, M.D., 25520 Little Mack, St. Clair Shores 48081
Edward G. Siegfried, M.D., 229 S. Gratiot, Mt. Clemens 48043
Sydney Scher, M.D., 132 Cass Avenue, Mt. Clemens 48043
Earl A. Rinkenberger, M.D., 243 S. Gratiot, Mt. Clemens 48043
Daniel L. Rousseau, M.D., Monitor Leader Bldg., Mt. Clemens 48043
Delmo A. Paris, M.D., 18801 Ten Mile Rd., Roseville 48066
Kirwin H. Stief, M.D., 115 Cass Avenue, Mt. Clemens 48043

MANISTEE

Donald N. Schwing, M.D., Forest Clinic Bldg., Manistee 49660
David A. Wild, M.D., 84 Cypress St., Manistee 49660

MARQUETTE-ALGER

George M. Wilson, Jr., M.D., 1414 W. Fair Ave., Marquette 49855
Fredk. C. Sabin, M.D., 1414 W. Fair Ave., Marquette 49855

MASON

William F. Sutter, M.D., 220 S. James, Ludington 49431
Robert L. Ewing, M.D., 600 E. Tinkham, Ludington 49431

MECOSTA-OSCEOLA-LAKE

James L. Tyson, M.D., 1014 South State St., Big Rapids 49307
Leland A. Hickox, M.D., 1014 South State St., Big Rapids 49307

MENOMINEE

Herman R. Brukardt, M.D., 534 First St., Menominee 49858
William S. Jones, Jr., M.D., 1146 Tenth Avenue, Menominee 49858

MIDLAND

V. A. Marks, M.D., 2706 Louanna, Midland 48640
James A. Devlin, M.D., 115 Jerome, Midland 48640

MONROE

S. Newton Kelso, Jr., M.D., 116 Cole Road, Monroe 48161
Bernard Sisman, M.D., 130 Cole Road, Monroe 48161

MUSKEGON

H. Clay Tellman, M.D., 315 W. Clay, Muskegon 49441

Howard V. Sanden, M.D., 1643 Peck, Muskegon 49441
Clarence A. Vandervelde, M.D., 1470 Peck, Muskegon 49441
John D. Folsom, M.D., 1706 Peck St., Muskegon 49441
Leland E. Holly, II, M.D., 889 2nd Street, Muskegon 49441
Donald P. Stratton, M.D., 889 2nd Street, Muskegon 49441

NEWAYGO

J. Paul Klein, M.D., P.O. Box 111, Fremont 49412
Robert E. Paxton, M.D., 220 W. Pine, Fremont 49412

NORTH CENTRAL

Charles L. Oppy, M.D., Roscommon 48653

NORTHERN MICHIGAN

William L. McCullough, M.D., 115 Clinton St., Petoskey 49770
Leonard W. Reus, M.D., 226 Park Avenue, Petoskey 49770

OAKLAND

James R. Quinn, Jr., M.D., 880 Woodward Ave., Pontiac 48053
John H. McLaughlin, M.D., 604 North Woodward, Birmingham 48011
Shelby M. Baylis, M.D., 35 S. Johnson, Pontiac 48053
Edward E. Elder, Jr., M.D., 1116 Voorheis Rd., Pontiac 48054
Arnold L. Brown, M.D., 35 S. Johnson, Pontiac 48053
James A. Read, M.D., 610 N. Woodward, Birmingham 48011
Bruce D. Bauer, M.D., 3229 Woodward Ave., Berkley 48072
Carl H. Birkelo, M.D., 4680 Dixie Hwy., Drayton Plains 48020
Paul T. Lahti, M.D., 3600 W. 13 Mile Rd., Royal Oak 48072
Harold A. Furlong, M.D., 35 S. Johnson, Pontiac 48053
Richard R. Galpin, M.D., 525 Southfield Rd., Birmingham 48009
F. Michael Sheridan, M.D., 1307 S. Washington, Royal Oak 48067
Donald G. Albert, M.D., 3535 W. 13 Mile Rd., Royal Oak 48072
John R. Lichtwardt, M.D., 3535 W. 13 Mile Rd., Royal Oak 48072
Edgar J. Geist, Jr., M.D., 1500 Walton Blvd., Rochester 48063
Peter A. Duhamel, M.D., 310 W. University, Rochester 48063
James E. Henderson, M.D., 909 Woodward Ave., Pontiac 48053
Raymond L. Mayor, M.D., 35 S. Johnson, Pontiac 48053
Richard C. Reilly, M.D., 909 Woodward Ave., Pontiac 48053
Ralph D. Wigent, M.D., Pontiac Motor, Glenwood Ave., Pontiac 48053
Worth W. Henderson, M.D., 1307 S. Washington, Royal Oak 48067
Kenneth L. Urwiller, M.D., 909 Woodward Ave., Pontiac 48053
Robert L. Tupper, M.D., 86 Ottawa Drive, Pontiac 48053
Charles R. Sempere, M.D., 35 S. Johnson St., Pontiac 48053

OCEANA

John J. Vrbanac, M.D., 22 N. State St., Hart 49420
Willis A. Hasty, M.D., 204 N. Michigan, Shelby 49455

ONTONAGON

Karl E. Hill, M.D., 9 Hemlock St., White Pine 49971
James P. Strong, M.D., RR 1, Box 406, Ontonagon 49953

OTTAWA

William Rottschaefer, M.D., 601 Michigan Avenue, Holland 49423
Frank L. Groat, M.D., 631 Franklin St., Grand Haven 49417
Peter J. DeVries, M.D., 321 Washington Avenue, Grand Haven 49417
Peter J. Verkaik, M.D., Hudsonville 49426

SAGINAW

Vernon V. Bass, M.D., 3322 Davenport, Saginaw 48602
Robert J. Toteff, M.D., 2110 Morson, Saginaw 48602
Duane B. Heilbronn, M.D., 1703 N. Michigan, Saginaw 48602
Roy J. Gerard, M.D., 2419 Mackinaw, Saginaw 48602
Robert G. App, M.D., 3422 Davenport, Saginaw 48602
Jack L. Barry, M.D., 5670 Dixie Hwy., Saginaw 48601
William A. DeYoung, M.D., 1100 S. Washington, Saginaw 48601
Edward F. Kickham, M.D., 705 Adams St., Saginaw 48602

ST. CLAIR

Alexander E. Hlivko, M.D., 1605 Fred W. Moore Hwy., St. Clair 48079
James H. Tisdel, M.D., 310 Water St., Port Huron 48060
John M. Miller, M.D., 1010 Griswold, Port Huron 48060
Harry E. Mayhew, M.D., 613 N. Riverside Dr., St. Clair 48079

ST. JOSEPH

Stanley C. Penzotti, M.D., 117 Spring St., Three Rivers 49093
S. *Albert Fiegel, M.D., 111 S. Monroe, Sturgis 49091*

SANILAC

Keate T. McGunegle, M.D., Sandusky 48471
Duane E. Smith, M.D., Brown City 48416

SHIAWASSEE

Claude L. Weston, M.D., Matthews Building, Owosso 48867
Henry T. Forsyth, M.D., 137 S. Saginaw St., Chesaning 48616

TUSCOLA

Robert R. Howlett, M.D., 624 W. Frank, Caro 48723
Edward J. Miles, M.D., Caro 48723

VAN BUREN

David J. Millard, M.D., Paw Paw 49079
Joseph E. Cooper, M.D., 417 W. Monroe St., Bangor 49013

WASHTENAW

Stuart M. Gould, Jr., M.D., Box 65, Mercywood Hospital, Ann Arbor 48107
John E. Magielski, M.D., St. Joseph Mercy Hospital, Ann Arbor 48105
Clarence E. Crook, M.D., St. Joseph Mercy Hospital, Ann Arbor 48105
Harry A. Towsley, M.D., University Hospital, Ann Arbor 48104
John W. Henderson, M.D., University Hospital, Ann Arbor 48104
Beverly C. Payne, M.D., 425 E. Washington, Ann Arbor 48108
Henry A. Scovill, M.D., 1313 West Cross, Ypsilanti 48197
Howard R. Williams, M.D., 1950 Manchester Rd., Ann Arbor 48104
Robert J. Fisher, M.D., 116 Park St., Chelsea 48118
Edwin H. Place, M.D., 2616 Hawthorne Rd., Ann Arbor 48104
Robert S. Ideson, II, M.D., 2200 Vinewood, Ann Arbor 48104
William R. Rekshan, M.D., 425 East Washington, Ann Arbor 48108
Joseph V. Fisher, M.D., 116 Park, Chelsea 48118
George H. Koepke, M.D., University Hospital, Ann Arbor 48104
Alexander Gotz, M.D., 2201 Medford Rd., Ann Arbor 48104

Neal A. Vanselow, M.D., Dept. of PG Med., University Hospital, Ann Arbor 48104

WAYNE

James C. Danforth, Jr., M.D., 20175 Mack Ave., Grosse Pte. Woods 48236
James D. Fryfogle, M.D., 15901 W. 9 Mile Rd., Southfield 48075
George L. Reno, M.D., 970 Fisher Bldg., Detroit 48202
Frank B. Bicknell, M.D., 938 Dav. Whitney Bldg., Detroit 48226
Brock E. Brush, M.D., 2799 W. Grand Blvd., Detroit 48202
James B. Blodgett, M.D., 76 W. Adams St., Detroit 48226
Sidney Adler, M.D., 3011 W. Grand Blvd., Detroit 48202
Homer M. Smathers, M.D., 17620 W. McNichols, Detroit 48235
Donald N. Sweeny, Jr., M.D., 8445 E. Jefferson, Detroit 48214
Luther R. Leader, M.D., 3535 W. 13 Mile Rd., Royal Oak 48072
Wyman C. C. Cole, Jr., M.D., 1063 Fisher Bldg., Detroit 48202
Edward J. Tallant, M.D., 18041 Greenfield, Detroit 48235
Marjorie Peebles Meyers, M.D., 3790 Woodward, Detroit 48201
Paul J. Connolly, M.D., 3800 Woodward Ave., Detroit 48201
George S. Fisher, M.D., 1709 Dav. Whitney Bldg., Detroit 48226
Francis P. Rhoades, M.D., 2414-16 Broderick Tower, Detroit 48226
Raymond J. Barrett, M.D., 18280 Fairfield, Detroit 48221
Louis E. Heideman, M.D., 3800 Woodward Ave., Detroit 48001
Charles E. Darling, M.D., 673 Fisher Bldg., Detroit 48202
James M. Kennary, M.D., 4900 Cadieux Rd., Detroit 48224
C. Jackson France, M.D., 17800 E. Eight Mile Rd., Detroit 48236
Alexander Blain III, M.D., 2201 E. Jefferson, Detroit 48207
John G. Slevin, M.D., 1132 Whittier Ave., Grosse Pte. Park 48236
John W. Moses, M.D., Mt. Carmel Mercy Hospital, Detroit 48235
Robert H. Hamburg, M.D., 1515 David Whitney Bldg., Detroit 48226
Benjamin Jeffries, M.D., 19959 Vernier Rd., Harper Woods 48236
Ned I. Chalat, M.D., 1553 Woodward Ave., Detroit 48226
William J. Yott, M.D., 854 Lakeside Rd., Detroit 48236
William L. Brosius, M.D., 1823 Fairoak Ct., Rochester 48063
Alfred H. Whittaker, M.D., 3 Elmsleigh Lane, Grosse Pte. 48230
Loyal W. Jodar, M.D., 18412 Mack, Grosse Pte. 48236
Arthur B. Levant, M.D., 15715 E. Warren, Detroit 48224
Sidney E. Chapin, M.D., 125 N. Military, Dearborn 48124
Irvin A. Wilner, M.D., 17701 McNichols Rd., Detroit 48235
Robert D. Allaben, M.D., 18255 W. McNichols Rd., Detroit 48219
Eli J. Igna, M.D., 2799 W. Grand Blvd., Detroit 48202
Leon Rottenberg, M.D., 13419 Fenkell Ave., Detroit 48227
Alex H. Hirschfeld, M.D., 3790 Woodward, Detroit 48201
Harold V. Morley, M.D., 970 Fisher Bldg., Detroit 48202
Joseph A. Witter, M.D., 344 Glendale Ave., Highland Park 48203
Eugene L. Freitas, M.D., St. Johns Hospital, Detroit 48236
Homer A. Howes, M.D., 1515 David Whitney Bldg., Detroit 48226
H. Ross Hume, M.D., 3800 Woodward Ave., #406, Detroit 48201
Z. Stephen Bohn, M.D., 327 Professional Bldg., Detroit 48201
Harry Y. Kasabach, M.D., 1553 Woodward Ave., Detroit 48226
Reuben I. Shapiro, M.D., 22341 W. 8 Mile Rd., Detroit 48219
Thomas M. Flake, M.D., 13800 Livernois Ave., Detroit 48238
Fred E. Caumartin, M.D., 17184 Wildemere, Detroit 48221
Laurel S. Eno, 212 Eastland Professional Bldg., Detroit 48236
Walter F. Kujawski, M.D., 17800 E. 8 Mile Rd., Detroit 48236
Vincent J. Gallant, M.D., 16766 Ashton, Detroit 48219
Ralph H. Pino, M.D., 48151 W. Ann Arbor Rd., Plymouth 48170
Joseph O. Reed, Jr., M.D., 448 Lincoln, Detroit 48230
George Mogill, M.D., 3150 Second Blvd., Detroit 48201
Ernest L. Stefani, M.D., 18455 James Couzens Hwy., Detroit 48235
John W. Sigler, M.D., Henry Ford Hospital, Detroit 48202
Henry M. Domzalski, M.D., 15252 Gratiot Ave., Detroit 48205
Frank B. Walker II, M.D., 1206 Balfour Rd., Grosse Pte. Park 48230
Eugene T. Capuzzi, M.D., 24644 Gleneyrie Dr., Southfield 48075
Lee E. Feldkamp, M.D., 360 N. Main, Plymouth 48170
Paul R. Dumke, M.D., 2799 W. Grand Blvd., Detroit 48202
Elden C. Baumgarten, M.D., 1062 Lochmoor Blvd., Grosse Pte. Woods 48236
Carl J. Sprunk, M.D., 2900 Oakwood Blvd., Belvindale 48127
Marshall J. Blondy, M.D., 19009 W. 7 Mile Rd., Detroit 48219
Richard D. Anslow, M.D., 1515 Dav. Whitney Bldg., Detroit 48226
Lyle W. Korum, M.D., 18585 E. Warren St., Detroit 48236
Richard S. Kamil, M.D., 14438 McNichols, Detroit 48235
Thomas Ganos, M.D., 6742 Park Ave., Allen Park 48101
Fredrick Weissman, M.D., 20905 Greenfield Rd., Southfield 48075
Charles J. Holt, Jr., M.D., 1210 S. Oxford, Grosse Pte. 48236
Robert A. Gerisch, M.D., 1217 Dav. Whitney Bldg., Detroit 48226
Walter L. Anderson, M.D., 1553 Woodward Ave., Detroit 48226
Carl A. Gagliardi, M.D., 3516 Fort St., Lincoln Park 48146
Robert C. Thumann, Jr., M.D., 20045 Mack Ave., Grosse Pte. Woods 48236
Louis R. Zako, M.D., 7720 Allen Rd., Allen Park 48101
John W. Moynihan, M.D., 2841 Monroe Blvd., Dearborn 48124
John F. Cotant, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Arthur A. Ulmer, M.D., 79 Greenbriar, Grosse Pte. Shores 48236
Earl E. Weston, M.D., 18101 Jas. Couzens Hwy., Detroit 48235
Michael N. Zelenock, M.D., 15830 Fort, Southgate 48192
Gerald H. Mandell, M.D., Sinai Hospital, Detroit 48235
Donald I. Bryan, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Robert E. McKnight, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Everal M. Wakeman, M.D., 155 S. Denwood, Dearborn 48124
Horace F. Bradfield, M.D., 3008 E. Grand Blvd., Detroit 48202
Paul M. Zavell, M.D., 92 Moran Rd., Grosse Pte. Farms 48236
Andrew R. W. Climie, M.D., Harper Hospital, Detroit 48201
E. Clarkson Long, M.D., 19751 James Couzens Hwy., Detroit 48235
Arthur M. Clark, M.D., 401 River Lane, Dearborn 48124

Edward G. Forgrave, M.D., 18520 Grand River, Detroit 48219
Gilbert M. Bazil, M.D., 14200 Puritan, Detroit 48227
Alfred Golden, M.D., 26764 York Rd., Huntington Woods 48070
Raymond J. Kokowiez, M.D., 19440 Van Dyke, Detroit 48234
James R. Lloyd, M.D., 1515 Dav. Whitney Bldg., Detroit 48226
Laurence J. McNichol, M.D., 18424 W. McNichols Rd., Detroit 48219
John H. Williams, M.D., 18633 Mack Ave., Detroit 48236
Frank W. Prust, M.D., 1536 David Whitney Bldg., Detroit 48226
James P. Gallagher, M.D., 6535 Allen Rd., Allen Park 48101
N. Doyle McGlaughlin, M.D., 2312 Biddle Ave., Wyandotte 48192
Jean M. Holdredge, M.D., 3011 W. Grand Blvd., Detroit 48202
John M. Shuey, M.D., 17198 Oak Drive, Detroit 48221
John J. Siller, M.D., 17000 W. 8 Mile Rd., Southfield 48075
Kenneth J. Ray, M.D., 28059 Elba Drive, Grosse Ile 48138
Leonard W. Melander, Jr., M.D., 1229 Dav. Whitney Bldg., Detroit 48226
Victor E. Nelson, M.D., 3025 Crooks Rd., Royal Oak 48073
Robert B. Clarke, M.D., 76 W. Adams Ave., Detroit 48226
Charles P. Anderson, M.D., Dept. of Social Service, 640 Temple Ave., Detroit 48201

WEXFORD-MISSAUKEE

Dennis E. VanAlst, M.D., 828 Oak St., Cadillac 49601
Lawrence O. Garber, M.D., 222 Howard St., Cadillac 49601

SECTION DELEGATES

ALLERGY AND APPLIED IMMUNOLOGY

James A. McLean, M.D., 1313 E. Ann St., Ann Arbor 48103
Norman W. Brey, M.D., 1900 Broderick Tower, Detroit 48226

ANESTHESIOLOGY

Ralph F. Askam, M.D., Medical Arts Center, Muskegon 49440
Bernard Sivak, M.D., 24665 Santa Barbara, Southfield 48075

DERMATOLOGY

Robert J. Schoenfeld, M.D., 800 S. Adams Road, Birmingham 48011
Alternate not elected

GASTROENTEROLOGY

Irving A. Warren, M.D., 18984 Livernois, Detroit 48221
Alternate not elected

GENERAL PRACTICE

Douglas A. Haddock, Jr., M.D., 6646 Portage St., Kalamazoo 49002
James F. Dooley, M.D., 3210 S. Dort Hwy., Flint 48507

INTERNAL MEDICINE

Carl B. Beeman, M.D., 515 Lakeside Drive, S.E., Grand Rapids 49506
Bert M. Bullington, M.D., 2000 Court St., Saginaw 48602

NEUROLOGICAL SURGERY

H. Harvey Gass, M.D., 529 Fisher Bldg., Detroit 48202
Robert S. Knighton, M.D., 2799 W. Grand Blvd., Detroit 48211

OBSTETRICS-GYNECOLOGY

Howard R. Williams, M.D., 1950 Manchester Road, Ann Arbor 48104
Alternate not elected

OCCUPATIONAL MEDICINE

Benjamin B. Holder, M.D., Box 469, Midland 48640
Alternate not elected

OPHTHALMOLOGY

(Not elected)

OTOLARYNGOLOGY

G. Donald Albers, M.D., 203 Paris Ave., S.E., Grand Rapids 49503
Jordan C. Ringenberg, M.D., 50 S. College Ave., Grand Rapids 49503

ORTHOPEDIC SURGERY

John O. Goodsell, M.D., 1600 N. Michigan, Saginaw 48602
Perry W. Greene, M.D., 515 Lakeside Drive, S.E., Grand Rapids 49506

PATHOLOGY

John R. McDonald, M.D., Harper Hospital, Detroit 48201
Harold E. Bowman, M.D., 201 Lafayette S.E., Grand Rapids 49502

PEDIATRICS

George L. Blum, M.D., 18200 Wyoming, Detroit 48221
Alternate not elected

PHYSICAL MEDICINE

(Not elected)

PLASTIC SURGERY

Edward J. Hill, Jr., M.D., 949 David Whitney Bldg., Detroit 48226
Alternate not elected

PROCTOLOGY

Donald J. Pearson, M.D., 255 North Ave., Battle Creek 49017
Alternate not elected

PSYCHIATRY & NEUROLOGY

Robert B. Clarke, M.D., 76 W. Adams Ave., Detroit 48226
Warren S. Wille, M.D., 5325 Brown Lake Road, Jackson 49203

PUBLIC HEALTH & PREVENTIVE MEDICINE

G. Frederick Moench, M.D., 147 Center, Sanford 48657
Winston B. Prothro, M.D., 1619 Walker St., N.W., Grand Rapids 49504

RADIOLOGY

Benjamin R. VanZwalenburg, M.D., 2116 Coronado S.E., Grand Rapids 49506
Karl K. Latteier, M.D., 15025 W. 8 Mile Road, Detroit 48237

SURGERY

John W. Derr, M.D., 1145 David Whitney Bldg., Detroit 48226
Alternate not elected

THORACIC SURGERY

None

UROLOGY

Robert C. Thumann, M.D., 2004 Mack Ave., Grosse Pte. Woods 48236
James M. Pierce, Jr., M.D., Wayne State Univ., Detroit 48207

Extract of MSMS Council Minutes

Meeting of July 18-19, 1968

The Council received a report from the Chairman of the Michigan Delegation to the American Medical Association, Luther R. Leader, M.D.

A final report of the Ad Hoc Committee to Study MSMS Relationships with Blue Shield was adopted by The Council and the supplementary comments and suggestions were referred to an appropriate standing committee for study and report. In brief, the Committee recommended that the relationships between Blue Shield and MSMS be continued and communications improved.

CONTINUING PAST POLICY, The Council authorized the inviting of osteopaths to attend the MSMS Annual Scientific Session upon recommendation of component medical societies. The Council enlarged this policy so that all non-member practicing physicians may be invited to the scientific meetings with no registration fee.

The Council authorized MSMS representatives to attend the AMA Annual Communications Institute and Conference of County Medical Society Officers in Chicago and the Second National Congress on Medical Ethics.

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

The Council appointed Norman D. Henderson, M.D., as the MSMS representative to an advisory board of study American Medical Association-University of Michigan chapter. The Council also presented to the Director of Michigan Department of Public Health nominations for the Laboratory Facilities Council.

Speaker James B. Blodgett, M.D., reported to The Council that the Committee on Procedures, of the House, had two major recommendations that introduction of resolutions should be permitted at the first and second meetings of the House only, except by consent of 2/3rds of the Delegates and that the President should be installed at a dinner meeting at the House on Tuesday evening. The remainder of the 61 responses were referred to a committee for study.

THE COUNCIL APPROVED Finance Committee amendments to the MSMS budget reflecting an anticipated increase in income and an anticipated decrease in annual expense, thus increasing the sum available for principle and interest payments by some $13,000.

Regarding the Beaumont Memorial, the Council requested the Beaumont Committee to clarify the legal, financial and moral responsibility that MSMS has to the Beaumont Memorial.

The Council reviewed annual summaries of committee activities which will be presented to the House of Delegates, approved the preliminary report of the Council to the House of Delegates, and reviewed minutes of committees which had met since June 5, 1968.

THE COUNCIL MET WITH representatives of the following groups and organizations: Michigan Department of Social Services; Michigan Health Council; MSMS Judicial Commission; Michigan Hospital Association; and Michigan Medical Service.

The Council received a report from insurance counsel on company representatives re malpractice insurance and referred this to the Professional Insurance Committee for study and report.

Meeting of June 5, 1968

AMA-ERF checks were presented to representatives of the Michigan medical schools by President Harris and Chairman Mason. The American Medical Association-Education and Research Foundation Checks went to Wayne State University Medical School ($6,911), University of Michigan Medical School ($12,203), and Michigan State University College of Human Medicine ($1,317).

The Council received a report from Treasurer John R. Ylvisaker explaining the format of operations for the Board of Managers (which is responsible for the new asset management plan) and reported that the Board had created, as authorized by The Council, a capital reserve account.

THE REPORT FROM Michigan Medical Service was presented by Lewis F. Hayes, M.D., Vice-President, concerning Medicaid experience over a 12 month period, information on analysis of claims experience, variable fee program status and Title XIX underwriting.

In anticipation of future problems, The Council decided to study the desirability of MSMS involvement in contract negotiation and created, therefore, an ad hoc study commission on negotiating contracts for medical services.

The Council authorized MSMS representatives to attend the National Conference on Rural Health sponsored by the AMA, the AMA Congress on Environmental Health Problems, and the AMA Regional Legislative Conference in Chicago.

The Council also authorized distribution of special reports about other state medical society annual meetings to The Council, Delegates and Alternate Delegates to the AMA and MSMS Delegates.

Oscar D. Stryker, M.D., was appointed MSMS representative for planning a workshop on smoking and related disease to be conducted by the Michigan Academy of General Practice in October.

APPROVAL WAS GIVEN to continued MSMS cooperation in the automotive crash injury research program of the Cornell Laboratory, which is continuing its study to evaluate recent automotive design modifications in Michigan.

A. C. Stander, M.D., Saginaw, was appointed as The Council representative to the Michigan Hospital Association convention.

The Council directed that MSMS prepare a response to the proposed actions of the Michigan Community Health Services Study.

The Council favorably approved a request from the American Public Health Association for financial support of its meeting to be held in Detroit. A modest sum was appropriated.

Upon recommendation of the Finance Committee, The Council also approved a grant to finance an education project for the Michigan State Medical Assistants Society.

The Council reviewed the minutes of the many committees of MSMS which had held meetings since the last meeting of The Council.

REGARDING PROFESSIONAL liability insurance, because of rapid developments in this area, The Council requested to the MSMS insurance advisor to prepare a complete report on professional liability insurance prospects and possible advantages of group-sponsored plans with specific recommendations for Council consideration in July.

For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

MD Placement Notice

—Looking for a smaller town that needs and wants a physician?

—Do you need an associate or assistant in your practice?

—Are there towns in your area in need of additional physicians?

—If your answer is YES to any of the above questions, contact

Michigan Health Council
John A. Doherty, Executive Secretary
712 Abbott Rd., P.O. Box 431
East Lansing (Phone: 337-1615)
(No charge for this service)

COMING EVENTS

ASIM President To Address Michigan Internists at Gaylord

The Michigan Society of Internal Medicine will hold its annual meeting in conjunction with the American College of Physicians Regional Meeting at Hidden Valley (Otsego Ski Club) Gaylord, September 19 and 20.

On Thursday evening, September 19, R. Gerald Rice, M.D., Director of the Michigan Department of Health will speak on "Comprehensive Health Plannings," and Larry H. Birch, M.D., Director, Regional Medical Programs, University of Michigan Medical Center, Ann Arbor, will discuss "Regional Medical Programs—Past, Present, and Future."

Robert S. Long, M.D., of Omaha, President of the American Society of Internal Medicine, will be featured at the noon luncheon meeting, Friday, September 20. His topic will be "The Efficient Internist."

Arthur W. Strom, M.D., Hillsdale, will be installed as president of the Michigan Society of Internal Medicine, succeeding John R. Caldwell, M.D., Detroit. □

Heart Transplant Surgeon To Offer '69 Beaumont Talk

The surgeon who has performed the highest number of heart transplant operations in the world, Denton A. Cooley, M.D., from the Baylor University College of Medicine at the Texas Medical Center in Houston, will deliver the 1969 Beaumont Lecture at the Wayne County Medical Society Building. Doctor Cooley has proformed four human heart transplants.

"The subject of Doctor Cooley's lecture, 'Transplantation of the Human Heart,' says Conrad R. Lam, M.D., chairman of the Beaumont Lecture Committee, "is certainly the most current in the interest of everyone, and its place in the list of Beaumont lectures will add another important milestone in the history of medicine as recorded in the chronology of the lectures."

The lecture is scheduled for Monday, April 7, 1969. □

Better Hearing, Speech Convention to Follow MSMS Annual Session

Neonate testing and early rehabilitation of hearing impaired children will be the central theme when Michigan Association for Better Hearing and Speech holds its two-day fall convention at the Pick-Fort Shelby Hotel, Detroit.

Marion P. Downs, a clinical audiologist, who has developed a program of newborn hospital testing, will give the keynote address Friday morning, September 27, at 9:30. Miss Downs, director of clinical audiology at the University of Colorado Medical Center, Denver, has lectured and written extensively on her program which is now used routinely in nine Denver hospitals.

Chairman of the Friday program, planned to be of special interest to doctors, is Royal C. Hayden, Jr., M.D., Detroit area otologist and director of the Henry Ford Hospital Otological Research Laboratory.

G. Fred Moench, M.D., director of the Midland City-County Health Department, is MABHS president. □

MEDISCENE

Sept. 4-5 — Conference for Physicians and Nurses, St. Mary's Lake

Sept. 22-23-24 — MSMS House of Delegates, Sheraton-Cadillac Hotel, Detroit

Sept. 24-26 — Woman's Auxiliary to the MSMS, Annual Convention, Statler-Hilton Hotel, Detroit

Sept. 24-26 — MSMAS Annual Session, Pontchartrain Hotel, Detroit

Sept. 25-26 — MSMS Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

Oct. 9 — Family Life Education Workshop, MSMS Headquarters, East Lansing

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Oct. 20-26 — National Community Health Week

Oct. 23-24 — Michigan Tuberculosis and Respiratory Disease Association Annual Meeting, Hayes Motor Hotel, Jackson

Oct. 24 — Michigan Thoracic Society Annual Meeting, Hayes Motor Hotel, Jackson

Oct. 30-31 — Symposium on Neuroendocrinology of Human Reproduction, McGregor Conference Center, Wayne State University

Nov. 6 — The Council, MSMS Headquarters, East Lansing

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

Dec. 1-4 — AMA Clinical Convention, Miami

Dec. 18 — The Council, MSMS Headquarters, East Lansing □

To Cos Add "t" from Trouble And It Spells Cost . . .

BY WILLIAM S. McNARY, PRESIDENT
MICHIGAN HOSPITAL SERVICE

Cos is where it all started.

And who knows where it will end.

Cos is a ragged, little Greek island of about 20,000 souls. Not far from the southwestern corner of Asia Minor, the island is the second largest of the Dodecanese, a lovely word to say, in any language.

Hipprocrates, the "father of medicine," was born on Cos about 460 B.C. And it was on Cos that he established the first medical school and the first hospital, as we think of them.

The local folk tell tourists that Hippocrates, the school and the hospital all thrived in the shade of a beautiful plane tree, whose truck now measures 30 feet around and whose immense, gnarled branches must be supported by pillars.

From these beginnings, many wonders have been wrought, as we all know, by what we now call our health care system.

SUCH WONDERS INDEED!

With heart transplants, our physicians — not our philosophers nor our religious leaders — have brought us face-to-face with the stark demanding questions of, "What is life?" and "Who shall have it?" These questions must be answered, and very soon.

Because of the growth of this health care system that benefits us all, we now are in such serious difficulty on the cost question that it is of great national concern. Perhaps health care costs don't rank with racial problems, inflation, poverty, big city crime and foreign involvements, but they're well up the list and have been climbing like a rocket for two decades.

What might be the principal root of this problem that faces all of us has been explained by D. Eugene Sibery, executive director of the Greater Detroit Area Hospital Council. Gene says:

"There is considerable cogency to the charge that we, in fact, do not have a health care system, if by system we mean an orderly arrangement which assures proper interrelationship and coordination between the various components."

The costs racked up by this sprawling health care industry rank as the nation's third largest category of spending (behind food and construction). Worse, it's rising at about twice the rate of the cost-of-living.

THERE CAN BE LITTLE DOUBT that costs cannot continue to climb in this fashion. If permitted to do so, we would be spending, sooner than you think, all of our gross national product on our health. Of course, this cannot and will not be permitted.

A fierce furor already exists about health care costs. Those of us who work in this field have been nervously aware of this for years. The concern now is being expressed everywhere. It's a frequent subject for popular journals. It's a hot topic of common conversation. It draws continual comment from government spokesmen.

At the conslusion of the National Conference on Medical Costs last year in Washington, a most astute and plain-spoken man, John W. Gardner, then Secretary of Health, Education and Welfare, said of our health care system:

"We cannot go on as we have in the past. New patterns will be necessary. Those who entertain some apprehension as to what the new patterns will be, had better plunge in and experiment with their own preferred solution."

Mr. Gardner added something very important: "The aspirations of the American people for health care are apparently without ceiling . . . these vaulting aspirations pose serious problems for those whose task is to achieve the goals. Aspira-

This article, which appeals for "state and local planning to create a voluntary health care system to replace our present uncoordinated, basically inefficient conglomeration of good, fair and poor health care facilities" appeared in the recent Annual Report of Michigan Hospital Service. It is reprinted with the permission of Mr. McNary and MHS. Appreciation is voiced for the use of the illustrations.

tions run into the hard reality of resource constraints."

In a November letter to Gardner, AFL-CIO Pres. George Meany talked even tougher and harder.

MEANY URGED IMMEDIATE, effective controls on doctors' fees. "There is no excuse whatsoever," he said, "for this relentless escalation in physicians' fees, especially those charged under the Medicare program."

Whether his fact base is sound or shaky, a man of Meany's stature and influence does not make such startling proposals without having in his mind a clear intent that could carry the day much sooner than those enraged by his statement may believe possible.

In an interview with the magazine *Medical Economics,* Jerome B. Pollack, professor of the economics of medicine at Harvard and a former Michigan Blue Shield director, said:

"Inevitably, government will play a larger role in achieving a better health system . . .

" . . . The government is in medicine because the public wants it there, and if doctors continue to fight government at every point — even in those areas where government has legitimate interest, such as the welfare of the people — then Washington is just going to take over the whole thing.

"That happened in England and it can happen here. That's what doctors really have to fear."

I THINK JERRY IS wrong about the extent to which the public wants government in medicine.

But if these voices are too political, too shrill, too liberal for you, try this!

Good Housekeeping magazine surveyed 1,000 American women on the way their health care needs are being met. Although the survey asked only for their views on costs, the magazine — which is not given to sensationalism — concluded:

"It (the survey) clearly touched a raw nerve. For women everywhere spontaneously poured out their wide-ranging complaints.

"Whether they singled out excessive dental charges, exorbitant eyeglass costs, soaring hospital bills, incredible surgeons' fees, budget-wrecking prescription costs, welfare chiseling, insurance deficiencies, Medicare failings, callousness of specialists, laziness of hospital personnel or encroachment of socialism into the medical field, (they) revealed an almost bottomless well of discontent."

Because of the discontent, some dractic things have been happening in the field of health care.

For instance, Michigan Blue Cross has had to defend its Hospital Qualifications Program in a legal battle that carried to the State Supreme Court.

TOO FREQUENTLY, WHILE unquestionably acting completely in the public interest, we've been accused of being a monster, of inhibiting free enterprise or of acting dictatorially.

The ogre most frequently used to threaten those who oppose even minor experiments bearing on the cost question is GOVERNMENT MEDICINE.

It's a tired and tattered old scarecrow.

And it's worthless.

It's not that I'm against government. It's just that I don't believe the government can provide a satisfactory solution to this complicated problem.

Medicare and Medicaid in our country and the dractic approaches used by other nations prove that shifting the financing mechanism to another location or jurisdiction means absolutely nothing in terms of effective cost control.

Last November, in the report of the Federal government's National Advisory Commission on Health Manpower, it was concluded (and placed in italics for emphasis):

"Government alone is not big enough to solve the problems of health care for the American people."

EVEN MORE RECENTLY, the Gorham Report (HEW's Report to the President on Medical Care Prices) said:

"The Federal government . . . cannot make a major impact on the efficiency of medical care delivery without the cooperation of the medical profession, the hospital industry, insurance carriers, State and local governments and many other public and private groups."

In such a complicated and emotionally-charged field as health care, the problem has many, many facets. I could, for instance, provoke each of you to argue with some heat and personal application about such statements as:

- There are too many hospital beds . . . and you will cite the recent time when you or someone you know had to wait a week or two to get such a bed.

- Drug research and production are expensive . . . but you want the latest and absolutely best medicine when you need it — and you seem to need a lot.

- Nurses salaries are too low . . . and you'll relate how service was poor and the nurse never was there when you wanted her.

- There are too many small, inefficient hospitals . . . but you don't want to drive even 10 miles twice a week for your mother's radiation therapy — so you fight to save "our hospital" down the street.

- There are not enough doctors . . . but they make too much money, except for your personal physician, who is a fine man, terribly overworked, to whom you say frantically, "Save my daughter; I'll pay anything."

RATHER THAN ARGUE these points (which are, by the way, very pertinent), could I ask you to reflect instead on two relatively simple questions?

The first was suggested by my friend, J. Douglas Colman, president of the New York City Blue Cross Plan.

"It is clinically impossible," he said, "to insulate an individual from the cumulative effects of his own neglect or self-indulgence. Citizens must accept the responsibility to minimize the need for health care."

The truly intriguing question that resulted from dwelling on his comments is:

Can the American individual, through his or her own education and effort, affect the kind of personal control of his demands for health care that will make unnecessary the massive, forced cost controls he seems to be demanding?

Interesting!

Despite the amazing accomplishment of the American people in individually improving their health, the answer probably is, "No." The evidence supports John Gardner's comment that "the aspirations of the American people for health care are apparently without ceiling."

But I'm not so sure.

Perhaps in 10 or 15 years, the current explosion in higher education will produce changes we will find almost unbelievable.

AS WE PROGRESS, can we not expect — with advances in individual health care and with vastly-improved applications of environmental health and preventive medicine, both of which are now beginning to get the emphasis they deserve — some relief in the cost of the treatment of illness?

This is not a fascinating possibility. It's a fascinating probability.

I really do hope that, through education, people will improve their environment and benefit so greatly from preventive medicine that their need for expensive treatment due to sickness or injury will plummet.

We now think of the health care system as providing for people only when they are ill or injured. In many, many instances, this is a "lock the barn door" proposition.

Environmental health and preventime medicine, too long outside the fold of the health care industry, are complicated. They embrace much not now considered a concern of our hospitals and doctors (who have enough to do just treating the sick and injured).

I refer to air and water pollution, mental stress, personal health habits, sanitation in the home, diet and — most of all — education in all such subjects.

But, as responsible realists with a most pressing problem, we must view this happy tomorrow only as an eventual safeguard against our immediate dilemma.

In the meantime, if the answer to the above question really is negative, and if we agree that health care costs cannot continue to increase at the current rate or anything near it, the next question is a tough and disagreeable one.

Who will apply the control, backed by force, required to reduce the increases in the cost of health care to an acceptable level — and how will it be done?

Those in the health care field have worked mightly on cost control. More and more is being done every day. I could fill pages just briefly mentioning these efforts. The box below lists only a few:

- Health facility planning
- Progressive patient care
- Coordinated home care
- Group institutional purchasing
- Eliminating duplication of expensive equipment in neighboring facilities
- Closing of outmoded facilities
- Merging of several small hospitals into a single modern service center
- Shared services, i.e., laundry, X-ray, blood banks, computer services, etc.
- More use of modern management techniques from industry and business
- Better division of labor to reduce routine work by trained specialists
- Greater fee standardization by physicians
- More group practice in its various forms
- Multiphasic screening of patients
- Preadmission testing to reduce lengths of stay in hospitals
- Health education and counseling
- Cost and quality control in hospitals
- Reduction in benefit duplication by prepayment plans and insurance firms
- Incentive payment plans for hospitals and hospital employees
- Flat negotiated fees to hospitals or doctors
- Intensive review and audit of services and costs

Believe it or not, there are large and influential groups of individuals — most of them fine people — staunchly opposed to and working actively against most of the proposals in this list.

And there is widespread public understanding of and support for almost none of them.

LET ME COMMENT BRIEFLY on just the first item — health facilities planning.

Michigan Blue Cross supports health facilities planning through its Hospital Qualifications Program, which I mentioned earlier. It's one of the most potent weapons in our cost control armamentarium to conserve the dollars of our 4½ million members.

The highly-regarded findings of the National Commission on Community Health Services — commonly known as the Folsom Report — said in 1966:

"The rapid rise in the cost of hospital care . . . is a matter of grave concern . . . The Commission takes the position that further increases . . . must not be accepted complacently."

One of its recommendations on cost was:

"Regional health-planning councils should be responsible for initiating and coordinating health facility planning for the region."

Yet, in the next year, the equally-prestigious National Advisory Commission on Health Manpower, said in what is now known as the Miller Report:

"Although there is considerable evidence to support this belief, we are skeptical of the value of giving planning agencies the authority and responsibility to approve or disapprove individual hospital projects . . . We doubt that planning councils will have sufficient objectivity and wisdom to make decisions always in the best interests of the entire community . . ."

Such a divergence of opinion among two groups of top-level national leaders, who studied at great length and presumably had available to them the same information, is difficult to comprehend.

THE QUESTION REMAINS on the table. Who is to control cost and how?

This is not a bitter lament, like those so popular these days with men who wish to appear learned and profound, but who end with a challenge, "It's up to you to do something or the government will."

It should be pointed out that the resolution of the real conflict in this situation rests with the American public.

Walter E. Landgraf, writing for the September-October issue of the *Harvard Business Review*, put it a bit stiffer. Executive Director of the Allegheny General Hospital in Pittsburgh, Landgraf says:

"Public attention has mainly been focused on voluntary nonprofit hospitals . . . But the problem of rising costs and financial health services is not the sole property of the voluntary hospital; it is also the problem of society."

At the present time, everyone wants unlimited medical care — the best, the newest, the most. It has become a "human right" with almost constitutional status. But the fast-rising costs are creating a squeeze on other needs.

I'm sure we all realize — or should — that when costs are controlled, quality may be jeopardized.

Health care may have become an American right, but where such rights are guaranteed, whether by government or anybody else, the guarantee almost always assures only the minimum.

Cutting costs is not difficult.

As Harper Hospital Board Chairman Ray Eppert said in the January issue of *Hospitals* magazine:

"We could cut costs tomorrow just by arbitrarily reducing the quality of the product — that which goes on with the patient while he is in the hospital. We could also reduce our teaching and research. Instead of moving forward, we could stagnate. But our goal . . ."

In my opinion, the really intelligent approach is to agree not just on how to control costs, BUT ALSO on how to do it in a sound manner that will assure the highest quality of care possible.

Not easy!

Really worthwhile endeavors rarely are.

THAT'S WHY I HAVE but three observations, the most important one having to do with the public — which must make the important decisions.

All segments of the health care industry must work continually and at a much greater rate of speed to produce effective cost controls, while at the same time holding firmly to the highest possible quality standards.

This proposal, which encompasses the many, many suggestions in the voluminous studies made of every single part of the health care industry by public and private organizations, is the responsibility of health care experts.

It will call for far more cooperation and agreement than we've had in the past. The system is riddled with very serious conflicts . . . from the seemingly-praiseworthy desire of an individual, organization or community to establish a hospital where none is neded . . . to the unnecessary bickering that goes on between nurses' organizations about the shortage of nurses . . . to the suspicion with which profit-making nursing homes regard those who hold that profit should not be a prime motivation in the treatment of sick people . . . to the condemnation by too many physicians of everything but the traditional solo practice.

The list of expensive conflicts is long.

We must make continuing and greater efforts to resolve them.

The public must become more aware of its true interest — which is to obtain a workable balance between quality health care and a cost that is bearable.

Too long now, the problem has been in the hands of health care professionals, who cannot always shed their bias and who operate in an area where true competition has virtually ceased to exist.

We should stop expecting the rabbits to take care of the cabbage patch.

Health care professionals must be more willing, through free discussion and informational programs, to help the public understand the basic issues.

And the public must be listened to.

The current public attitude reflected in literature and in public and private studies is largely hostile criticism.

THE HOSTILITY HAS great potential. Because it expresses interest, it may bring public knowledge and understanding. This, in turn, may bring support for the cost-control mechanisms created by the health care industry, help resolve conflicts and answer questions those in the health industry cannot.

Much has been said of the value of an informed public. The American public's world-wide reputation for self-expression and determination is rapidly bringing itself to bear on health care costs.

We should apply our efforts through state and local planning to create a voluntary health care system to replace our present uncoordinated, basically inefficient conglomeration of good, fair and poor health care facilities.

The planning that has been done to date in many urban centers points the way. With much greater emphasis on the education of the public and of our state and local officials, there is no reason why we cannot keep voluntaryism in the saddle.

The people want good medicine, efficient institutions and reasonable prices.

ALL THINGS CONSIDERED, there is no reason why they cannot get these things from our voluntary health care system — to at least the same degree that industry provides its material blessings.

It is our collective job to make sure they do.

Blue Cross is ready, able and willing to help.

If the health care industry performs, as in my first suggestion, and if the public understands, as in the second, and if truly public groups can establish sound patterns with reasonable economic limits, then we can hope to avoid repeating our own errors — and those of others.

ACTIVITIES, PROJECTS

UNETHICAL TO USE PRESCRIPTION BLANKS WITH Rx IMPRINT

The ethic of physicians using prescription blanks with the name of a pharmacy printed thereon has been considered by the MSMS Judicial Commission. Donald N. Sweeny, Jr., M.D., Chairman, MSMS Judicial Commission, reports the Commission gave this matter careful study.

Under the authority invested in the Commission in Chapter 11 Section 8 (b) (Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.) of the MSMS Bylaws, have reaffirmed the 1964 opinion of the Judicial Council of the American Medical Association as follows:

> **It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon**

To insure that there be no misunderstanding on this matter by pharmacists, the Michigan State Pharmaceutical Association has been informed of the action and requested to make it known to pharmacists throughout the state. ☐

CANCER FOUNDATION ADDS MAN

Frank Jakes, Ph.D., formerly of Ford Motor, has been appointed by the Michigan Cancer Foundation, as executive vice president for community affairs. He will be responsible for development and coordination of educational, promotional and community service programs as well as other executive type assignments.

Doctor Jakes has been with Ford for 10 years as a training specialist in the industrial relations department, and with WSU. ☐

WIVES RATE PLAUDITS

Wives of two Michigan doctors have achieved notable "firsts." Mrs. William Fishbeck, Traverse City, elected to a four-year term on the City Commission of Traverse City, will be the Commission's first woman member. Mrs. Thomas J. Mudge, Marquette, has been appointed to the eight-member Michigan Mental Health Advisory Council, the Council's first member from the Upper Peninsula. ☐

SEES KIDNEY MACHINES IN HOMES WITH DOCTORS GIVING FOLLOW-UP CARE

Joseph W. Eschbach, Jr., M.D., University of Washington, told the Seventh Annual Michigan Kidney Foundation Disease Symposium May 24 and 25 in Grand Rapids that patients with kidney failure must be cared for at home with the patient's local physician providing "astute follow-up care."

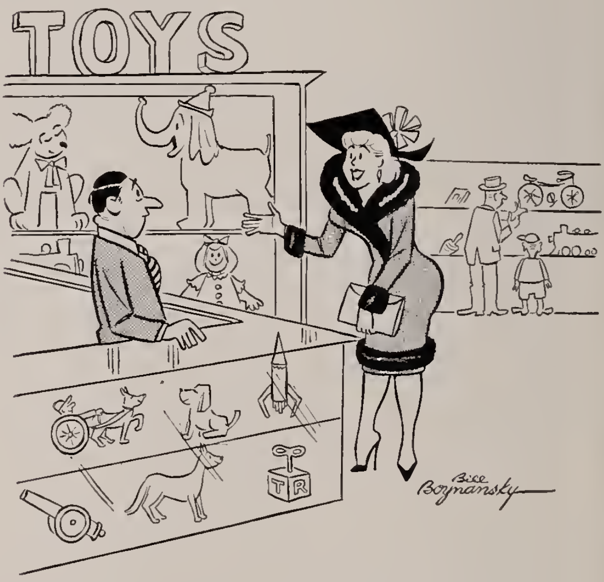
The follow-up, he said, will include office calls every one to four months and monthly blood tests.

The experience at the University of Washington Center, he said, has been that most local physicians are happy to take over care of patients after they are released. Many physicians have visited the center for instruction. He recommended eight to ten hours of dialysis three times weekly. ☐

A Social Imperative

"Sweeping societal change now dictates a reappraisal of this earlier philosophy which placed nearly its total investment in the education of the child. The impact of automation, the accelerated obsolescence of knowledge, increasing longevity, and the shrinkage of the world are all factors which now render the continuing education of the adult a social imperative."

— Edwin L. Novak, President
Michigan State Board of Education



"Where can I buy some of these mental blocks you hear so much about?"

Utilization Review Systems; Characteristics and Operation

ABSTRACT: The concept of a utilization review system is developed along the lines of a closed, (continuous) self-corrective process which brings together the basic components of medical care in a manner which allows qualitative and quantitative statements to be made about medical care. The basic components of the utilization review system are then described and contrasted with examples from operational systems.

BY CARL JOSEPHSON, DIRECTOR
UTILIZATION REVIEW RESEARCH PROJECT
MICHIGAN BLUE SHIELD

In two previous articles in this series, a number of forces in our society were shown to exert pressure on the medical care system to achieve the "best medical care for the most people at the lowest cost."

One method of both encouraging and measuring the progress toward this goal is through an effective utilization review system. The system, however, to be effective must be closed and self-corrective. That is, the review process must encompass all of the components of medical care — it must describe the medical goals of the community in quantifiable terms; it must evaluate the patient care that is being rendered, third-party payers, and socio-medical factors in the patient-doctor relationship. The system should be self-corrective in the sense that information gained from the review process is fed back into the medical system in a constructive manner. Utilization review committee reports, journal publications of changing patterns of medical care, and revised course curriculums are some of the continuing educational by-products of the utilization review system.

THE TRADITIONAL HOSPITAL-based utilization review system is organized around a review committee of staff physicians who look at preselected cases with the intent of evaluating the patient care and, where indicated, informing the attending physician of its findings. When the internal structure of the utilization review committee is analyzed and the many possible variations which can occur are enumerated, as illustrated in Chart I, the complexity of the problem is readily apparent.[1]

The purpose of the task is to maximize the effectiveness of the utilization review committee by the optimum allocation of available medical personnel to solve each hospital's particular utilization problems. As with the structure of the utilization committees, the actual review process contains a number of significant variations within the basic components. Some of these variations are shown in Chart II.

The time when a case is selected for review (i.e. type of review) is an important factor to consider in establishing a utilization review system since it influences the choice of other component variations. For example, the choice of concurrent review may be taken at the time of admission or at some stage during the inpatient stay. While this method can be used to effect the patient's continuing care (i.e. concentrate on "deviant" cases while they are in the hospital), it cannot evaluate the total medical care. Another type of review is the retrospective study which reviews the medical records of discharged patients. Retrospective re-

This is the third in the series of articles dealing with Utilization Review prepared by the staff of Michigan Blue Shield.

The author, Carl Josephson, is the director of the Utilization Review Research Project. He has had several years of experience in working on research projects for Blue Cross and Blue Shield plans ranging from the two national organizations in Chicago, Blue Cross Association and National Association of Blue Shield Plans to local plans in Michigan, Indiana and California.

—Louis F. Hayes, M.D.
Vice President, Medical Affairs
Michigan Blue Shield

view studies may sample all types of patient categories and review many components of patient care simultaneously. The manner of selection of cases for review ranges from complex models based on probability sampling of selected characteristics from the patient population, such as payment status, diagnostic category, and length of stay, to the review of an entire discharged patient population.

Retrospective studies employing computer techniques can secure data about patterns of patient care while performing the selection of cases. Many of the larger hospitals and hospital-based service bureaus are developing computerized screens to assist in the selection and initial evaluation of patients' records. Whenever the computer is employed to assist in the selection of cases or the evaluation of patient care, it is necessary to develop normative patterns of patient care and/or predetermined medical criteria as an index or baseline comparison. This is in contrast to the reviewer who relies on his own professional judgment on an *ad hoc* basis.

WITH SO MANY POSSIBLE variations in the components of a utilization review system, it is understandable that many different operational systems have evolved. The Monroe County study

Chart I

Utilization Review Committee Structure*

COMMITTEE COMPOSITION AND ORGANIZATION	VARIATIONS
Size	Numeric and variable
Membership	Physicians; administration; medical record librarian; social service; nursing; community members; health officers; etc.
Selection of Members and Officers	Elected or appointed by Medical Staff, Executive Committee, Utilization Committee, or Administration because of staff membership, position on medical staff, interest, or specialty
Term of Office	Rotation; non-rotating; some permanent members
Assignment of Cases	Full committee compliment, sub-committee units, or individual physician's review of all cases, cases by type of service, cases at random, or cases at specified time intervals
Frequency of Meetings, and Individual Review	At specified time intervals: daily, weekly, monthly, etc.; as needed
Responsibility of Members	Review of cases; formulation of policy of committee; formulation of standards for individual review
Relationship to Other Committees	Overlapping membership; informal discussions; subcommittee of other staff committee; no relationship

* Adapted from Greaney, Morisse, and Wilson, "A Study of Utilization Review Mechanisms Employed in Connecticut Hospitals," May, 1967; unpublished masters thesis, Yale University School of Medicine.

Chart II

Essential Components to the Utilization Review Process*

COMPONENTS	VARIATIONS
Type of Review	At time of admission; concurrent; retrospective
Case Selection	Total patient population; diagnostic categories; deviant cases; either all or on a sampling basis
Components of Patient Care Reviewed	Necessity of admission; length of stay; delays in diagnostic and therapeutic procedures; delays in consultation; quality of care received
Data Sources	Insurance records; medical record (full record, abstract, face sheet, check list); physician interview; patient observations
Method of Evaluation	Ad hoc peer judgment (individual or group basis); predetermined medical criteria

* Ibid

and the Nassau County pilot study, for example, were developed to test two systems of utilization review. While both systems used retrospective review by individual reviewers, the former relied on *ad hoc* professional judgment and the latter on informal, but flexible, predetermined criteria. Variations between different reviewers as well as variations between the same reviewers at different time intervals were found to be less pronounced where the use of predetermined criteria was followed.

Under the New Jersey A.I.D. system (Approval by Individual Diagnosis), a concurrent review system using certification techniques was developed with the assistance of three outside agencies — New Jersey Medical Service, New Jersey Hospital Association, and the Blue Cross-Blue Shield Plans. Each patient upon admission is given an estimated length-of-stay according to the admission diagnosis. Should the patient's stay extend beyond this estimate, a form indicating the necessity for continuing care must be completed by the patient's physician. Copies of this certification form are attached to the patient's chart and sent to the hospital utilization review committee.

IN CONTRAST TO individual case review methods, the HUP (Hospital Utilization Project) has developed a patterns review technique whereby electronic data processing methods are used to obtain data from all hospital discharges. Specific diagnostic groups are analyzed so that inter- and intra-hospital comparisons can be made on patterns of patient care. HUP is sponsored by the local medical societies and Blue Cross Plan of western Pennsylvania. Each hospital completes an abstract form from the medical record of all discharge cases. These abstracts are coded and compiled into a case listing for use by the hospital as a screening device. HUP in addition prepares a series of comparative statistics and special reports which highlight significant variations in patterns of care that would justify the attention of a hospital utilization review committee.

As with all of the systems described so far, individual case review is still performed within the hospital; however, the emphasis is placed on reviewing patterns of normal care rather than deviant use. HUP provides technical consultation to assist the local hospitals in their interpretation and use of their reports.

The Professional Activities Study (PAS) began in 1950 as an experiment in centralized collecting and processing of data on hospital medical care. It began with a few hospitals in Michigan and expanded to include hospitals throughout the United States, Puerto Rico, Canada, and New Zealand. PAS is similar to the HUP system in that it uses case abstracts for data collection and prepares case listings and monthly comparative statistical reports and summaries. The case abstracts, however, are more detailed as are the statistical reports. When interpreted correctly, the reports can be used for retrospective review of admissions, duration of stay, evaluation of professional services furnished, and the appropriate use of hospital facilities and services.

THE EXISTING UTILIZATION review systems are developed mostly for use by hospital staffs. As such, they tend to concentrate on individual case review techniques and are seldom used for evaluating the patterns of medical care being rendered in the community. The growth of third-party prepayment systems financing a significant proportion of the health care dollar and insuring large population groups have precipatated evaluative studies of the efficiency and effectiveness of the organization and delivery of medical care. The accumulation and centralized processing of records by these health carriers have provided another dimension to the review system. Redefinitions of the units of measurement and changes in the emphasis from specific deviant cases to measurement of normative patterns of care will provide the necessary base-line statistics that can lead to comprehensive problem definitions and corrective programs. ☐

Staudacher Leaves Post As SAMA Executive

Russell F. Staudacher, MSMS staff member from 1949-51, retired June 30 after 18 years of service as the executive director of the Student American Medical Association. Mr. Staudacher, who suffered a heart attack last December, is serving as consultant to several associations.

Charles Hewitt, former attorney and administrative assistant for the American Academy of General Practice, will succeed Mr. Studacher. ☐

DIRECTORY AVAILABLE OF SERVICES TO AGING

The Michigan Commission on Aging has issued a new "Directory of Services" which may be of interest to some physicians. A copy is available from the Commission, 1101 S. Washington, Lansing 48913.

The Directory provides general information about programs and assistance available to older people, how to apply for such benefits as the Homestead Tax Exemption, and opportunities in employment, recreation and education. ☐

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Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MSD **MERCK SHARP & DOHME** Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Report on Michigan Regional Medical Program

BY DON MARSHALL, M.D., KALAMAZOO
REPRESENTATIVE OF MSMS TO MARMP
VICE PRES., BOARD OF DIRECTORS, MARMP

The Officers, Council and Delegates of the MSMS, as well as the general membership, should keep informed of the progress of the Heart, Cancer, Stroke Program in this state. They should consider and decide a number of questions regarding the program. They should aid in a study of medical needs in Michigan that might properly and advantageously be met by this program.

Considering first the program from the national aspect, there is little doubt that the RMP is here to stay for the foreseeable future. Congress is pleased with it so far, it is doing good, much initial skepticism is disappearing, and it is now firmly started in all states. The program is being administered as originally outlined, with initiative and approval for the start of each project resting locally in the region, rather than in Washington. The program also is stimulating and demanding cooperation at the local level in a manner never before achieved. These are the two outstanding features of the law and its implementation: a) Washington approves nothing not first approved by the local region, and b) Washington approves no regional plan or activity that cannot first demonstrate that all concerned local groups are participating and agree on it.

UP TO THIS TIME the RMP (PL89-239) and the Comprehensive Planning Act (PL89-749) are cooperating closely, but the latter is not preparing to swallow the former. They are not alike, though they overlap in spots.

The factor in RMP that is beginning to blur is the limitation to heart disease, cancer, stroke and related diseases. These are medically so all-encompassing that to survey or study or educate for these categorical diseases alone simultaneously prepares often for similar action for all medical ailments. There early was urging that the categorical limitations be removed, and it seems likely that the first major change in the law will be in that direction.

The basic purposes of the RMP will bear repeating: 1) To reduce the time lag between the discovery and effective application of new knowledge, in the field of medicine; 2) To improve the quality and effectiveness of medical care; 3) To bring together the diverse groups in the health care field, for more effective results and to improve patient care.

Already 1,000 medical institutions are in various ways participating in the RMP. This includes every medical school and hundreds of hospitals. Eight hundred health organizations are participating, including every State Medical Society, every state health department, every state heart association and cancer society. The RMP in the U.S. employs over 1,800 salaried employees, full or part time, and over 7,000 non-Federal-connected individuals are active in it. The first planning grant was made two years ago; now about 24 regions have received or are in process of getting operational grants.

THE STEPS COVERED in setting up a regional program could be outlined as follows: 1) involvement and commitment of the individuals and institutions concerned; 2) the identification of needs and opportunities; 3) an assessment of resources, both physical, personnel, and ability; 4) determination of objectives; 5) setting priorities; 6) implementation; 7) evaluation of results.

The AMA supports the RMP so long as it continues to be administered as it has been, to catalyze and to facilitate better programs to serve patients and their physicians. In 5 of the 54 regions a State medical society is the program grantee, or heads the regional program. These are Georgia, D.C., Nebraska, Minnesota and Pennsylvania. The AMA testified before Congress in March that "We feel that the program has been administered very well, and with restraint and good judgment."

Since November 1967 the Michigan Association for Regional Medical Programs has had a central executive office in East Lansing headed by Albert

AUTHOR

DOCTOR MARSHALL

E. Heustis, M.D. The Board of Directors meets monthly and the Regional Advisory Group every three months. There are several professional advisory groups and task forces. In the coming year it is expected that a few field men will be hired to facilitate communication in the various areas of the state. The program everywhere has started around medical schools, but from Congress on down there is a clear desire and effort promptly to involve the profession and hospitals in smaller and rural communities.

TO DATE THE MICHIGAN State Medical Society has been involved in MARMP as follows: 1) It has an official representative on The Board of Directors; 2) Many of the committees of the Society are watching the program (Cancer, Cardiac Disease Control, Postgraduate Education, Rehabilitation, Aging, Diabetes, Rural Medical Service, Education Liaison, Cancer Coordinating); 3) To inform the society of MARMP activities a) a meeting of the chairmen of the committees listed above was held in October 1967; b) two programs on MARMP were given at the Annual Meeting in September 1967; and c) a variety of articles and announcements have been published throughout the year in *Michigan Medicine*; 4) Most of the scores of individuals active in MARMP today are MD's, and nearly all members of MSMS.

Despite all this integration of MSMS into the MARM Program, the point deserves reconsideration on whether the present participation of MSMS is all that it should be, and in the most efficient form. Much of the skepticism with which the medical profession met this national program at its start has disappeared, and has been replaced with support and even enthusiasm. The program is now a fairly husky baby of two years, with quite a potential for good that MSMS should be well aware of. It would seem logical that specific activities of MSMS in the Michigan RMP should be initiated and monitored by our various committees. In addition, county medical societies and the medical staff of all hospitals should become informed of the program and the potential for participation and help. Lastly any group or individual with suggestions or requests should feel free to communicate directly with either MSMS or with Dr. Heustis at the MARMP office, 1111 Michigan Avenue, East Lansing. ☐

MAEDC ISSUES HANDBOOK RE EMOTIONALLY DISTURBED

The Michigan Association for Emotionally Disturbed Children (MAEDC) has recently published a handbook which lists all Michigan services which are currently available for the care of emotionally disturbed children.

"Professional and lay members of MAEDC repeatedly have pointed out that there are directories on residential care for children, hospital services, and directories on educational programs, but nowhere is there one comprehensive listing of all services for disturbed children in Michigan," says Samuel L. Davis, Executive Director of the Association.

To fill the gap, the Association has published "Finding Programs for Troubled Children." It will be of special interest not only to pediatricians and general practitioners, but all physicians who are called upon to make reference for the care of children.

To receive a copy free of charge write: MAEDC, 668 Pallister Avenue, Detroit 48202.

Members of MAEDC are professionals and interested citizens dedicated to promoting the welfare of emotionally disturbed children. MSMS members on the MAEDC board of directors are William D. Harrelson, M.D., of Kalamazoo, Edward H. Rodda, M.D., of Bay City, and G. Fred. Moench, M.D., M.P.H., of Midland. ☐

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The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
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- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

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The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

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NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to
NCME, 342 Madison Avenue
New York, N.Y. 10017

Four Cities Receive Model City Grants

Under a new Model Cities Program, planning grants have already been awarded to four Michigan communities: Detroit; Genesee-Flint; Highland Park; and Saginaw.

Public Law 89-754, the Model Cities Program, is intended to revitalize the physical and social environment in blighted areas in cities and demonstrate that social and physical problems in these areas can be solved by concentrated and coordinated application of federal, state and local public and private resources in representative urban areas.

With federal assistance up to 80% of the local contribution, this program can be used to rebuild and revitalize large slum and blighted areas, expand housing, expand jobs and income opportunities, reduce dependents on welfare, improve educational facilities and programs, *combat disease and ill health,* reduce crime and delinquency, enhance recreational and cultural opportunities, establish better access between homes and jobs and in general, improve living conditions.

Michigan physicians will have a prime interest because health components in this program will be concerned with physical and mental health services and facilities excessible to and used by all residents of the area, including health education, personal services, diagnostic and therapeutic services, rehabilitative and restorative services, and areawide environmental health services.

This new program, as well as other federal programs, will attempt to utilize all available resources to attack serious social, economic and health problems and will seek coordination and assistance from MARMP (Michigan Association for Regional Medical Programs).

Other major provisions include the liberalization of FHA and mortgage insurance for group practice facilities, urban renewal, rural housing, land development in the new communities and urban information and technical assistance services.

Michigan Statistics About Health Care

The Health Insurance Institute recently released the following data on health care in Michigan:

Extent of Health Insurance Coverage for Persons Under Age 65 and Other Figures

Number of persons with hospital expense insurance	7,242,000*
Number of persons with surgical expense insurance	6,725,000*
Number of persons with regular medical expense insurance	5,967,000*
Number of persons with major medical expense insurance**	2,146,000
Total health insurance benefits paid (1965)	$608,910,000
By insurance companies for hospital, surgical and medical care, including loss of income	$273,625,000
By Blue Cross, Blue Shield, Medical Society-approved or-sponsored and independent plans for hospital, medical and surgical care	$335,285,000
Number of health insuring organizations licensed in the state (338 insurance companies, 2 Blue Cross, Blue Shield and Medical Society plans, and 7 independent plans)	347

Hospital Statistics (1966)***

Number of hospitals in state	200
Number of hospital beds available	30,966
Number of persons admitted during the year	1,115,897
Number of persons under hospital confinement on an average day	25,424
Number of full-time hospital personnel per 100 patients	265
Average length of time a patient remained in hospital	8.3 days
Average cost per hospital stay	$436.25
Professional Services	
Number of physicians in private practice (December 31, 1966)	6,603
Number of non-federal dentists (Mid-1966)	4,455
Number of registered, practicing resident pharmacists (Jan. 1, 1967)****	5,175
Number of employed professional registered nurses (1962)	21,465

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*Net total of people protected — eliminates duplication among persons under age 65 protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage.

**Persons under 65 years of age with insurance company coverage.

***Non-federal, short-term general and other hospitals.

****In practice in state.

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Vitamin B_1	7.5 mg
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Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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respond to specific therapy with
QUINAMM™
(Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

The Bettman Archive

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Top 12 Health Insurance Plans* in the USA

(Based on 1966 data from the *Argus Chart* published by the National Underwriter Company, and reprinted from the Michigan Blue Shield - Blue Cross Highlights publication)

	EARNED FEE INCOME	% PAID OUT IN BENEFITS	% USED FOR OPERATING EXPENSES**
1. Metropolitan Life	$718 million	84.3%	14%
2. Aetna Life	626½ million	88.7%	11%
3. Travelers	574 million	88.2%	11.4%
4. Prudential	503 million	77.8%	19.1%
5. New York City Blue Cross & Blue Shield	439 million	95.0%	7.1%
6. Michigan Blue Cross & Blue Shield	374 million	94.0%	4.7%
7. Equitable Society	363½ million	86.3%	11.5%
8. Continental Casualty	357½ million	70.0%	27.0%
9. Mutual of Omaha	356½ million	73.9%	26.8%
10. Connecticut General	241 million	88.1%	13.8%
11. Massachusetts Blue Cross & Blue Shield	223 million	95.1%	4.5%
12. New Jersey Blue Cross & Blue Shield	202 million	93.5%	5.0%

*Blue Cross is a name for 75 autonomous Plans sponsored by hospitals throughout the nation; total Blue Cross membership income for 1966 was $3 billion-plus. Likewise, Blue Shield is the generic name for 73 autonomous Plans sponsored by medical societies throughout the nation; total Blue Shield membership fee income for 1966 was $1.4 billion. Together, then, for 1966 Blue Cross and Blue Shield nationally had $4.14 billion income; this was greater than the premium income of the top 10 commercial companies combined.

The two other members of the "top 10 commercials" are John Hancock Mutual, $186 million income, and Bankers Life & Casualty, $164 million.

**Operating expenses, when added to benefits paid out, will not necessarily come to 100%. On their total health insurance business during 1966, most of the "top 12" were in a gain position. This, despite the fact that eight of the "top 10 commercials" registered losses on group business, one as much as $8 million. Where overall losses were sustained, losses were made up in one of three ways:

(1) adjustment of the fee charged;

(2) investment income, or

(3) subsidy by some other part of the fringe-benefit program. □

"Medical education is a continuum. Continuing education should be an integral part of the physician's life — from the time he enters secondary school until the close of his career."

— The Coggeshall Report

MSMS ANNUAL SESSION, SEPT. 25-26
SHERATON-CADILLAC, DETROIT

House of Delegates, September 22-23-24

TWO WAYS TO GIVE YOUR PATIENTS A MONTH'S SUPPLY OF THERAPEUTIC VITAMIN C:

45 CABBAGES OR 30 ALLBEE WITH C

ur patient would have to eat 45 cabbages a month 1/2 a day) to get as much vitamin C as is contained in one bottle of 30 Allbee with C capsules (taken one sule daily). In addition, each capsule provides full rapeutic amounts of the B-complex vitamins. For mple, as much niacin as 2 pounds of sirloin steak.

te "30" for B and C deficiencies. This handy bottle of Allbee with C capsules gives your patient a month's ply at a very reasonable cost. Also the economy size 100. Available at pharmacies on your prescription or commendation.

H. Robins Company, Richmond, Va. 23220.

30 Capsules
Allbee® with C
Each capsule Contains:
Thiamine mononitrate (Vit. B1) 15 mg
Riboflavin (Vit. B2) 10 mg
Pyridoxine hydrochloride (Vit. B6) 5 mg
Niacinamide 50 mg
Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg
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PHARMACY
DONNATAL
2 tablets
3 times daily

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in your practice
deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (Warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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TWO WAYS
TO GIVE
YOUR PATIENTS
A MONTH'S
SUPPLY OF
THERAPEUTIC
VITAMIN C:
45 CABBAGES OR
30 ALLBEE WITH C

ur patient would have to eat 45 cabbages a month 1/2 a day) to get as much vitamin C as is contained in one bottle of 30 Allbee with C capsules (taken one psule daily). In addition, each capsule provides full rapeutic amounts of the B-complex vitamins. For mple, as much niacin as 2 pounds of sirloin steak.

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Pyridoxine hydrochloride (Vit. B_6) 5 mg
Niacinamide 50 mg
Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg
A·H·ROBINS
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Main Street
PHARMACY
DONNATAL
2 tablets
3 times daily

the spasm
reactors
in your practice
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"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
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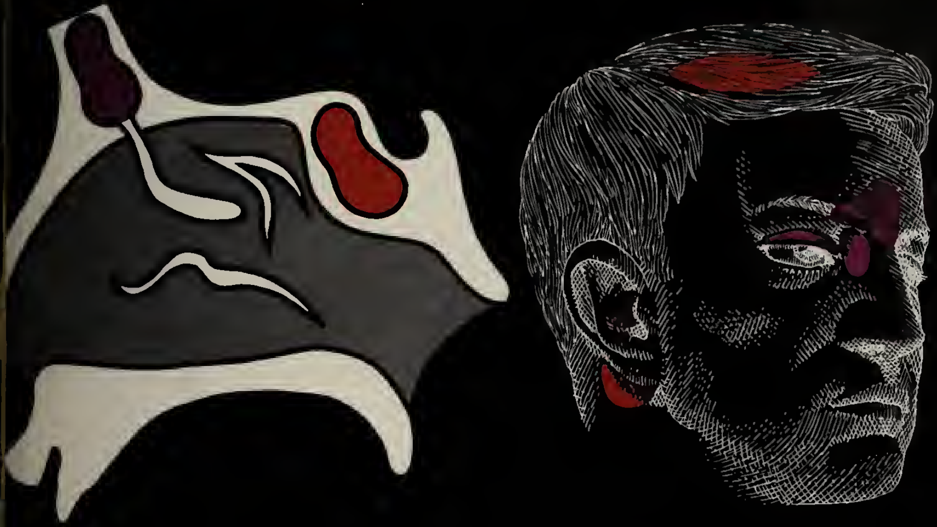
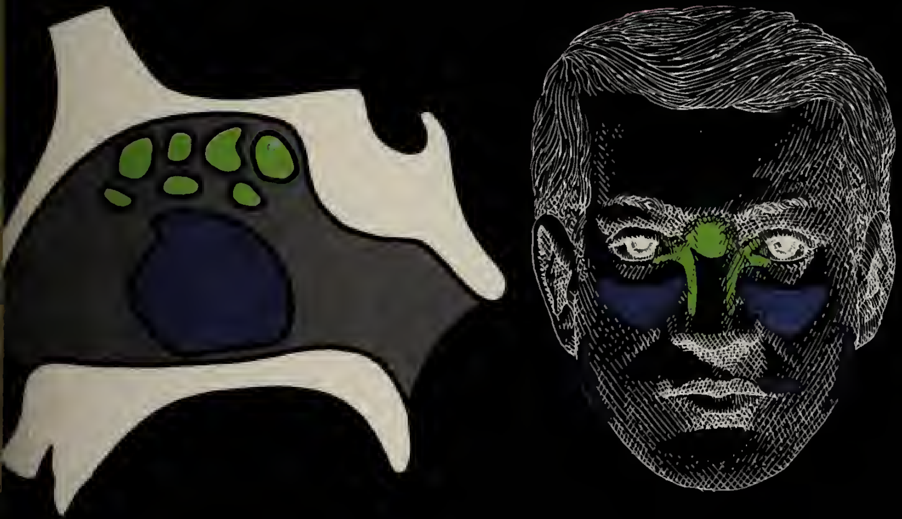
A·H·ROBINS

Sources of sinus headache

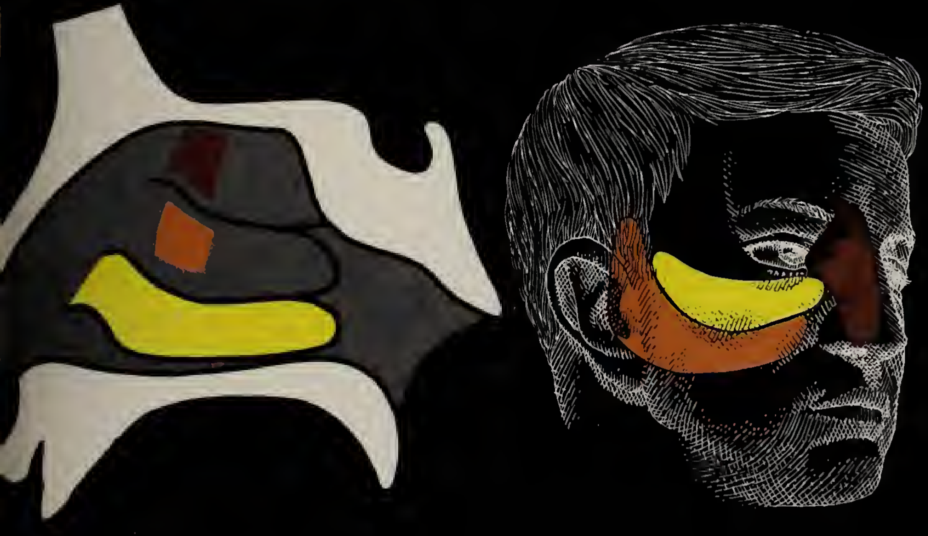


REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids. SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults–2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA
SINUTAB®
FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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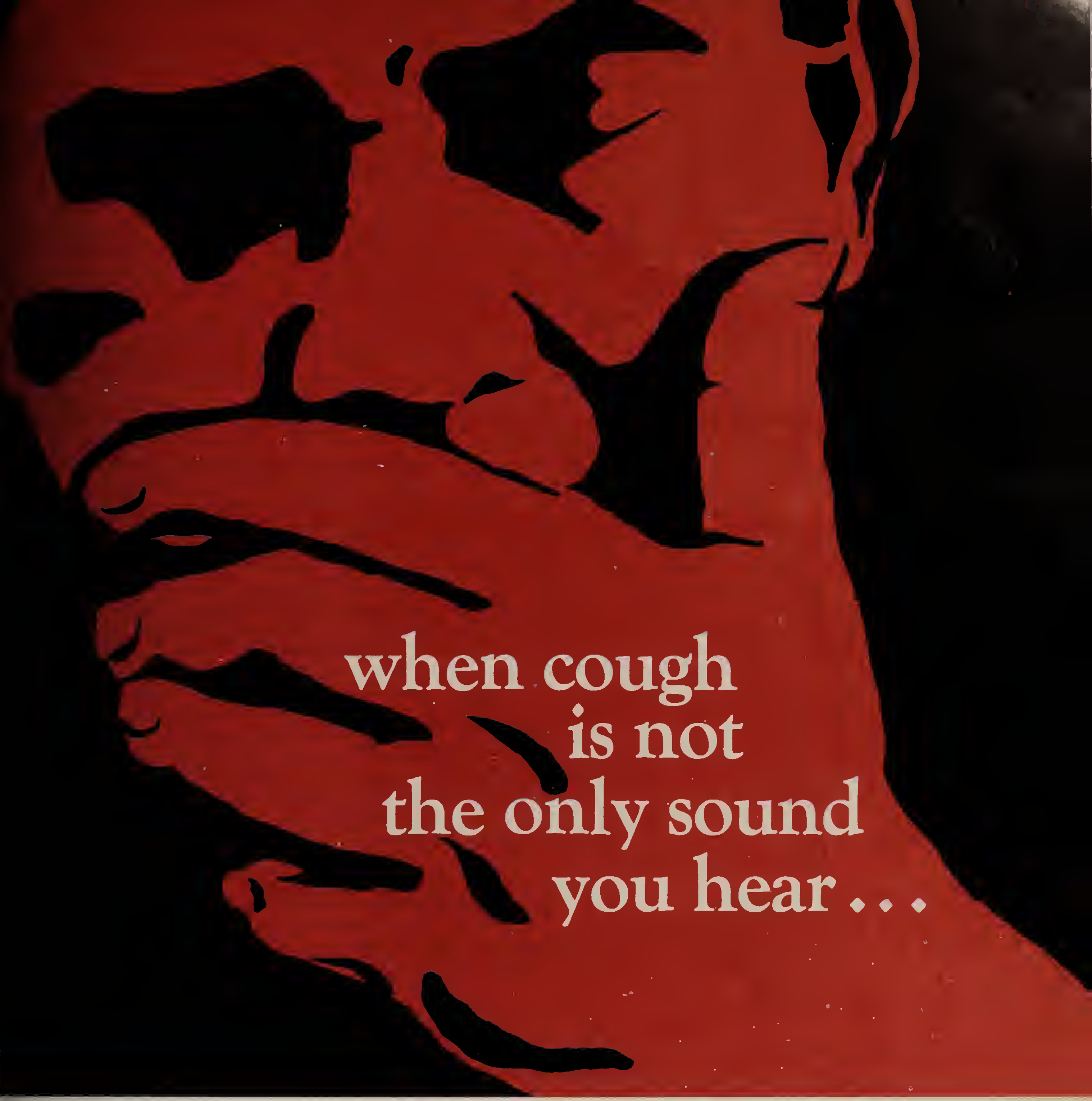

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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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new evidence for TAO® (triacetyl-oleandomycin)

No tooth staining reported after 10 years of use.

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macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1] Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%

of the organisms were susceptible to oleandomycin*

98.0%

of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2] Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

Roerig Rx

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In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients wh have previously exhibited a hypersensitivity reac (e.g., blood dyscrasias, jaundice) to phenothiazin Phenothiazines are capable of potentiating centr nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports leukopenia and/or agranulocytosis and convulsi seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmenta retinopathy may be avoided by remaining within recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., drivin Orthostatic hypotension is more common in fem than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System—* Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism an other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred visi constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System—* Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urtica type, photosensitivity. *Cardiovascular System—* Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizer including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any signifi disturbance of cardiac rhythm, several sudden a unexpected deaths apparently due to cardiac arr have occurred in patients previously showing electrocardiographic changes. The use of periodi electrocardiograms has been proposed but woul appear to be of questionable value as a predictiv device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxie and mixed anxiety-depressi

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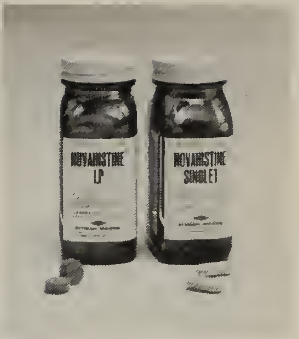

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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These Firms Make '68 Annual Session Possible without a Registration Fee

One of the colorful and educational aspects of the MSMS Annual Session in Detroit this September will be the interesting array of exhibits.

MSMS leaders say, "Take time to inspect each one — not just a casual look — but a real indepth study. You will be surprised at the wealth of new information they will offer you."

Following is a list of the firms who will be presenting displays at the 1968 MSMS Annual Session. Doctors are urged to make a special effort to visit each booth to personally express appreciation and to ask questions.

Income from the leasing of exhibit space makes it possible for MSMS to present its excellent Annual Scientific Session without a registration fee.

The intermission periods between scientific sessions will provide excellent opportunities to study the exhibition. The registration desk, meeting rooms, and exhibits will be conveniently located on the same floor as the meetings.

MSMS also wishes to express its gratitude to those who have generously made program grants to the Annual Session. These contributors are:

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Mead Johnson Laboratories
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Michigan Association of Collection Agencies
Michigan Bell Telephone Company
Michigan Blue Shield
North American Pharmacal
North States Aviation, Inc.
Ormont Drug & Chemical Company, Inc.
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Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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New State Laws, Now In Effect, Explained

(Editor's Note: This first article in a series describes the Senate bills which passed the 1968 legislature and were given immediate effect. Next month, an article will discuss the House-introduced new laws which went into effect upon being signed by the governor.

During the 1968 session, the Michigan State Legislature enacted 26 new important health laws, 11 of them originating in the Senate and the remaining 15 having been initially presented in the House.

In the case of each new law, however, unless the Legislature orders that the law shall become effective upon signature by the Governor, the law does not become operative until 90 days after the Legislature finally adjourns. Since it is now anticipated that the 1968 adjournment will come in late August, many new health laws will not have effect until the latter part of November, 1968.

This first article will discuss the salient features of those Senate bills which passed the entire Legislature, were given immediate effect and have been signed by the Governor. Any Senate bills not covered in this article may be assumed to lack effect for several more months (such as the new hospital licensing law, for example)´ and will be explained in a subsequent article published near the date the law becomes operative.

CHIROPRACTORS, under new Public Act 73 of 1968, now practice under the following definition: chiropractic is considered to be "the locating of misaligned or displaced vertebrae of the human spine, the procedure preparatory to and the adjustment by hand of such misaligned or displaced vertebrae and surrounding bones and tissues, for the restoration and maintenance of health."

The law now goes on to provide: A licensed doctor of chiropractic under this act may use X-ray and such analytical instruments as are approved by the Michigan board of chiropractic examiners in the examination of patients solely for the purpose of locating misaligned or displaced vertebrae of the human spine and for the procedures preparatory thereto.

It should also be noted that the law now provides that the Chiropractic board *may* suspend or revoke a chiropractor's license for: "being guilty of false, fraudulent or misleading advertising or advertising in which grossly improbable statements are made; or advertising in any publication or media free services or consultation, or the prices for which his services are available; or for having professional connection with any firm of corporation who advertises contrary to these provisions."

Persons noting a chiropractor advertising in such a manner as is prohibited above should, the law says, write to the Chiropractic board secretary (200 Lafayette Building, in Detroit), in triplicate. The board *may* call a hearing and can discipline the offender if it finds him guilty. It should be noted that this law has always given this board authority to discipline for "fraudulent," "grossly improbable," or "misleading" statements. The new element is the prohibition against advertising "FREE" services, or stating fees for services.

COUNTIES WITH LESS THAN 75,000 population which have not previously availed themselves of the provisions of the Community Mental Health Services Act, Act 54 of 1963, may now join in an existing program in an adjacent county, if the adjacent county's board of supervisors approves and if the State Department of Mental Health grants necessary approvals also. The new law making this possible is Public Act 205 of 1968.

IMPORTANT FLUORIDATION legislation was passed by the adoption of Public Act 346 of 1968, which makes two important provisions. First, it specifically prohibits any instrumentality of state government from ordering the fluoridation of water supplies. Second, it provides as a legislative action that *all* public water supplies must be fluoridated before July 19, 1973 *unless* the addition of fluoride has been rejected by an ordinance of the local governing body or by a majority of the electors voting on the question.

Townships and counties may now either operate, OR CONTRACT FOR, ambulance and inhalator services under the provisions of Public Act 163 of 1968. The law became effective on June 17 and provides "good samaritan" protection for ambulance drivers, attendants, policemen and firemen (except for acts or omissions constituting gross negligence or willful and wanton misconduct, as well as requiring the passage of a Red Cross first aid course by such persons before they are entitled to the protection of the law.

Here is a quote from the new statute: "The township board of any township and the board of supervisors of any county may operate or join with another municipality or contract with persons, firms, organizations or corporations in operating or furnishing an ambulance and inhalator service for the use and benefit of the residents of the township or county. The service by the town-

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ship or the county may be in connection with fire protection service or as a separate operation."

The Michigan law governing the Department of Social Services in its administration of the categorical aid programs (old age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled) has been amended by Public Law 232 of 1968 to permit third parties, acting in behalf of applicants, more latitude to function on the applicant's behalf. This new law, a purely technical administrative change, takes cognizance of the growing utilization of third parties.

Also in regard to the categorical assistance programs, the Legislature in passing Public Act 169 of 1968 has clearly stated that while other records, applications, etc. shall be open to inspection "All records relating to persons applying for, receiving or formerly receiving medical services under the categorical assistance programs . . . . shall be confidential and shall be used only for purposes directly and specifically related to the administration of the medical program."

THE FOREGOING SIX new health laws are presently in effect. Other important health legislation, which will not become effective until late November of 1968 and which will be reviewed in a future article, includes hospital licensing, added funds for alcoholism programs, sex education, waiver of basic science requirement due to passage of national boards, and making it a felony (rather than a misdemeanor) to practice medicine without a license.

The next article in this series will cover House-introduced new laws passed in 1968 which went into effect upon being signed by the Governor.

Hemophilia Clinic Slated Soon in Grand Rapids

An Evaluation and Diagnostic Clinic, sponsored by the Michigan Chapter, National Hemophilia Foundation, will be held Saturday, September 28, at Butterworth Hospital, Grand Rapids.

Physicians having hemophilic patients who would benefit from this clinic may contact the office of John Penner, M.D., Hemophilia Control, Room S 6360, University Medical Center, Ann Arbor, and an application and referral form will be sent.

Participating in the clinic will be Doctor Penner, G. Anderson, M.D., Grand Rapids; Genevieve Howen, M.D., Grand Rapids; Claude Raby DDS, Grand Rapids. ☐

U-M Hospital Predicts Need for $110 Million In Expansion by 1978

A long-range planning report prepared for the University of Michigan Hospital anticipates a construction program totaling about $110 million within the next decade "to meet the immediate health care needs" of the institution through the year 2000.

BLUE CROSS COMPUTERS SERVING LOCAL HOSPITALS

Michigan Blue Cross has added a new dimension in computer service for Michigan hospitals.

The Hospital Computer Services, a new division, offers to Blue Cross participating hospitals a complete range of computer services supported by a staff of professional consulting and systems people.

Wm. S. McNary, Blue Cross president, said, "This new program links Michigan hospitals to a central computer for the purpose of performing a number of administrative services — quickly, efficiently and at lower cost than any individual hospital could hope to achieve."

In this respect, Michigan Blue Cross is the first Plan in the country to have a pilot project that is working with clinical people and trying to adapt computer technology to clinical requirements. This is a job of magnitude and complexity with different objectives from that of the business office.

In carrying out this role, Blue Cross is uniquely capable because of its technological capability, experience, and economic strength already dedicated to minimizing hospital costs and improving patient care.

Recent studies have indicated that the need for information processing assistance to hospitals has become more acute as governmental, medical, administrative and population demands on hospitals have increased and become more complex. These demands necessitate increased expansion in clinical and administrative processing and reporting requirements. The federal government is already interested in the management techniques and economics of hospitals as well as the level or scope of patient care through its regional medical programs — programs like Medicare, Medicaid, and hospital and medical insurance for Federal Employees.

Cottage Hospital in Grosse Pointe Farms, was the first Michigan institution to elect to share the Blue Cross Hospital Computer Service. Art Center Hospital will join in September and Sinai Hospital in November. ☐

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING AUGUST 2, 1968

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	20	33	253	897
Whooping Cough	37	108	284	645
Diphtheria	0	0	0	0
Mumps	194	611	13,010	12,784
Scarlet Fever & Strep Sore Throat	445	530	7,041	9,472
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	0	0	0
Hepatitis	196	125	1,256	1,175
Salmonellosis (Other than S. typhi)	46	56	399	312
Typhoid Fever (S. typhi)	0	2	0	6
Shigellosis	37	22	154	281
Aseptic Meningitis	11	12	37	31
Encephalitis	4	14	52	81
Meningococcic Meningitis	4	10	63	50
Influenzal Meningitis	5	11	36	34
Tuberculosis	263	298	1,682	1,772
Syphilis	523	414	3,298	3,407
Gonorrhea	2,061	1,715	10,342	9,941

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

> *"Physicians have become increasingly concerned with their need for effective continuing educational opportunities in order that the advances in medical knowledge may be applied in practice with as little delay as possible."*
>
> *—AMA Guide Regarding Objectives and Basic Principles of Continuing Medical Education Programs*

MSMS ANNUAL SESSION, SEPT. 25-26

House of Delegates, Sept. 22-23-24

Established 1924

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Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

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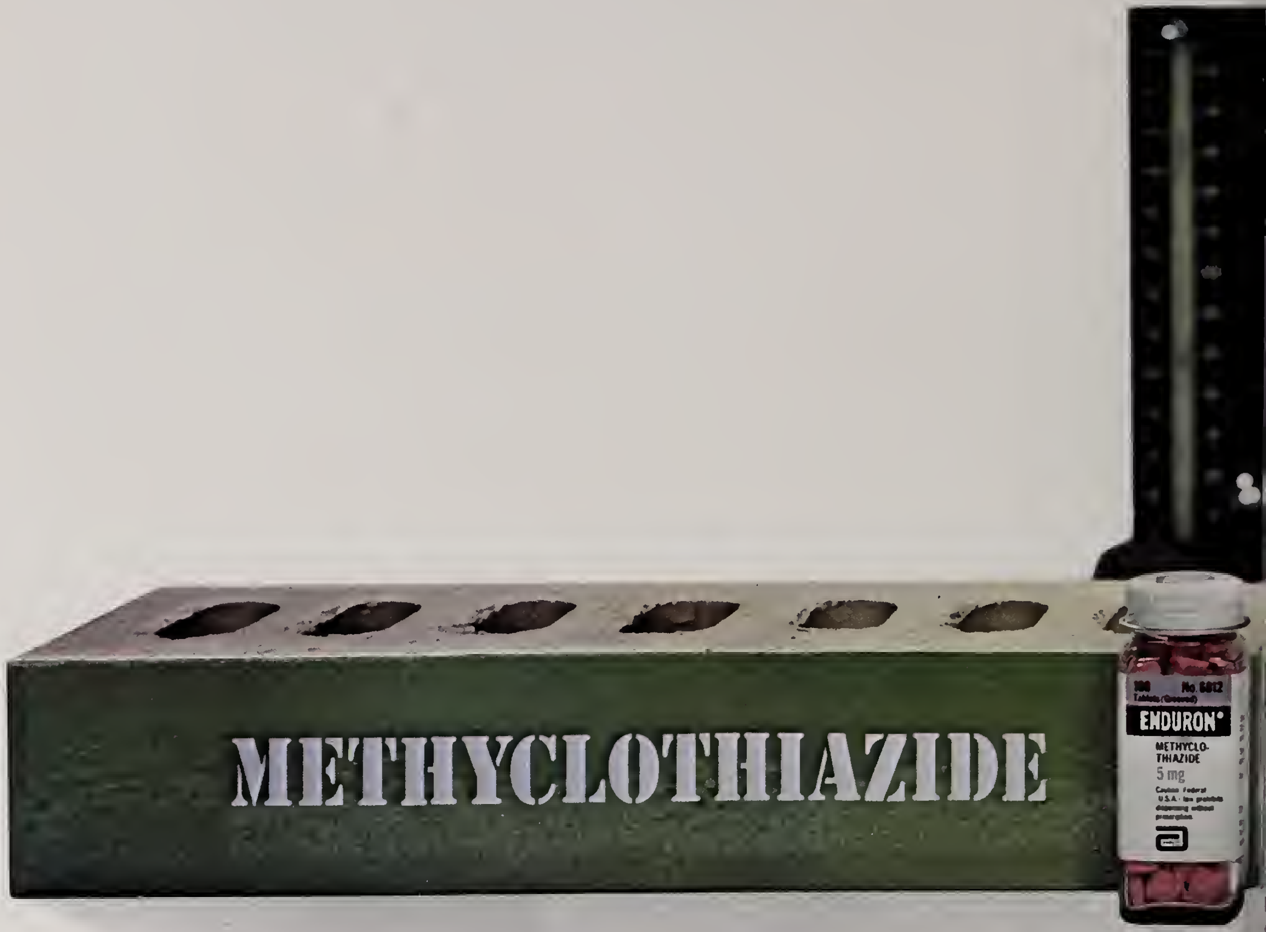
Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na$^+$ output, yet easy on the K$^+$

Enduron provides an excellent starting therapy. Your patien sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hou With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivene

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

MILD
TO
MODERATE
TO
SEVE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component
adds response in moderate hypertension

DESERPIDINE
METHYCLOT ZIDE
100 No. 6830
Tablets Grooved
ENDURONYL
Each tablet contains
Methyclothiazide 5 mg
Deserpidine 0.25 mg

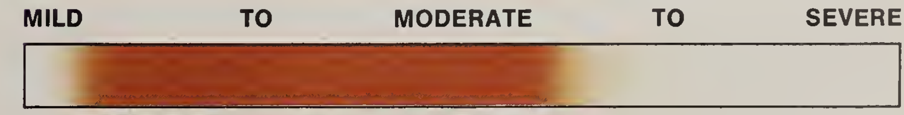
Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

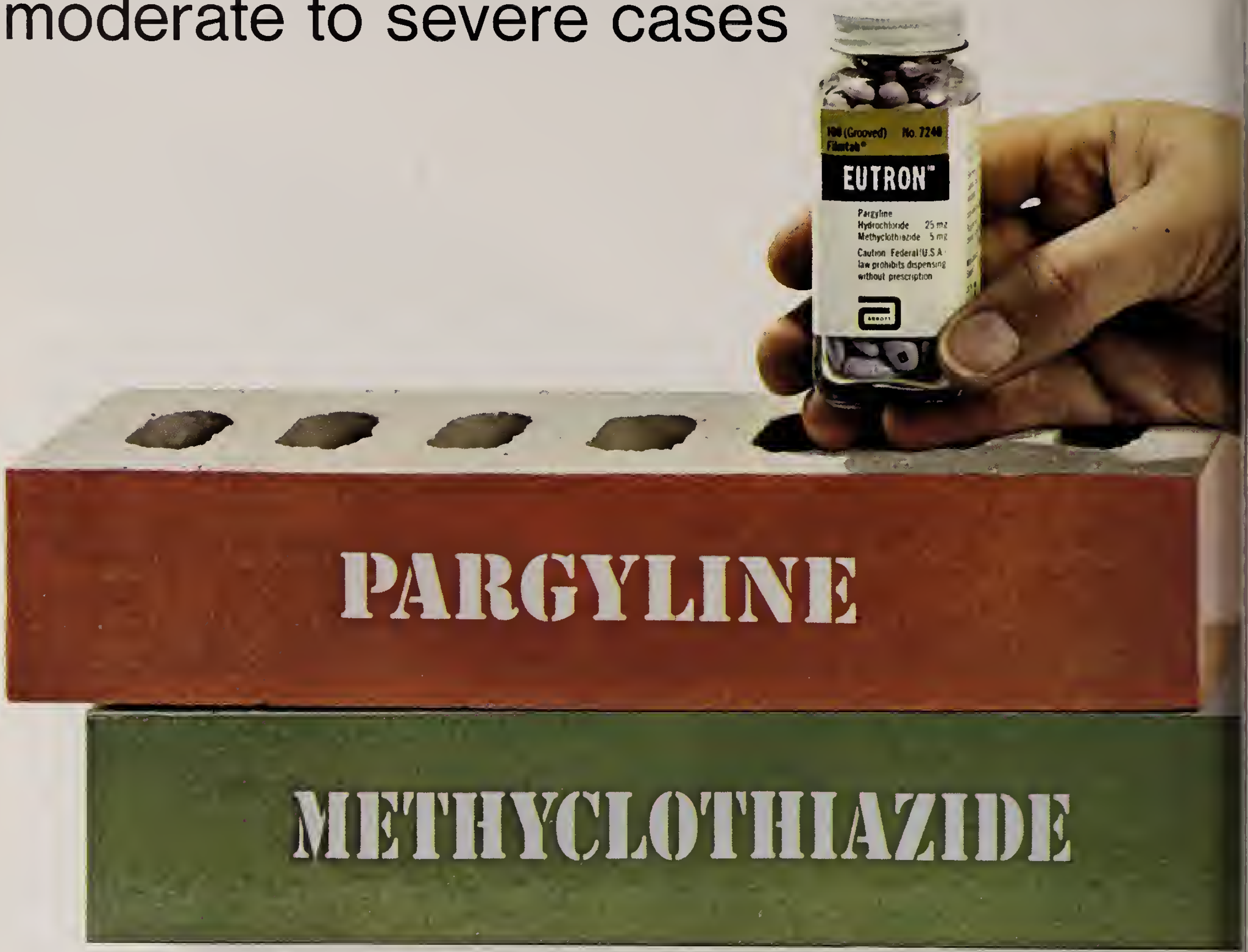


nce a day, every day
ENDURONYL®
ETHYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling
moderate to severe cases


100 (Grooved) No. 7240
Filmtab®
EUTRON™
Pargyline Hydrochloride 25 mg
Methyclothiazide 5 mg
Caution Federal (U.S.A.) law prohibits dispensing without prescription
PARGYLINE
METHYCLOTHIAZIDE

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day
EUTRON™
PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD
TO
MODERATE
TO
SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON®

METHYCLOTHIAZIDE

ENDURONYL®

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

TM-TRADEMARK

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

IN MEMORIAM

Lawrence Berman, M.D., Detroit

Lawrence Berman, M.D., professor at the Wayne State University School of Medicine, died July 8. He was 59.

Doctor Berman's teaching appointments at Wayne State University were Professor of Hematopathology, Associate in Anatomy, and Associate in Medicine. He was affiliated with Veterans, Oakwood, Beaumont, St. Joseph's, Mercy, Sinai, and Receiving hospitals in Detroit, and St. Joseph's Hospital, Pontiac.

He received the M.D. degree from the University of Minnesota in 1937. He interned at Minneapolis General Hospital, Minneapolis, Minnesota, 1936-37, and did a residency at the University of Minnesota Hospital from 1938-41. He did postgraduate studies in pathology and hematology and received the M.S. degree in 1941.

Doctor Berman was a member of the International Hematology Society, American Board of Pathology, American Society of Pathologists and Bacteriologists, American Society of Clinical Pathologists, College of American Pathologists, Phi Beta Kappa, Sigma Xi and Alpha Omega Alpha. He published extensively in scientific journals.

P. F. Coleman, M.D., Livonia

Peter F. Coleman, M.D., Livonia specialist in obstetrics and gynecology, died July 8 at the age of 64.

Doctor Coleman received his premedical education at City College of New York, New York City, and his M.D. degree from Rush Medical College, Chicago, Illinois, in 1930. Internship was done at the Cook County Hospital and Chicago Lying-In Hospital, 1930-31. His residency was at New York Polyclinic Hospital, 1943-45. He did postgraduate work at Basic Science University of Pennsylvania Medical School.

He was affiliated with St. Joseph Hospital and Grace Hospital, Detroit, and Plymouth General Hospital.

Doctor Coleman was a member of the American Society of Abdominal Surgeons and the American Board of Obstetrics and Gynecology. He was also a member of Kiwanis of Livonia and Phi Delta Upsilon medical fraternity.

A. J. Telego, M.D., Grand Rapids

Anthony J. Telego, M.D., pathologist at Blodgett Memorial Hospital, Grand Rapids, died July 18. He was 50.

Doctor Telego was graduated in 1949 from the Marquette University School of Medicine in Wisconsin. His internship was done from 1949-50 at E. W. Sparrow Hospital in Lansing, where he was a resident in pathology from 1950-51.

After three years in general practice in Youngstown, Ohio, Doctor Telego served in the U.S. Army Medical Corps, 1954-56, as Chief of Laboratory Service of the U.S. Army Hospital, Ft. Leonard Wood, Missouri. In 1956-57, he did a residency in pathology at Sibley Hospital and Hunter Laboratory, Washington, D.C. He joined the staff at Blodgett Hospital in 1958.

He was a member of the American Society of Clinical Pathologists, Association of Clinical Scientists, Association of Clinical Pathologists, Michigan Society of Pathologists, and Phi Chi fraternity.

A. E. Thomas, M.D., Detroit

Alfred E. Thomas, M.D., Detroit physician and civic leader, died July 1 at the age of 59.

Doctor Thomas received his M.D. degree in 1937 from Meharry Medical College and later served as a member of the Meharry Board of Trustees. He was awarded an honorary doctorate from Ferris Institute where he did his premedical studies.

During World War II, he served in the U.S. Army Medical Corps, earning the rank of Lieutenant Colonel. He was a flight surgeon for the 99th Pursuit Squadron stationed at Tuskeegee Army Airfield in Alabama, and he later served in Liberia, West Africa.

Long active in the NAACP in Detroit and nationally, Doctor Thomas was a member of the first Human Relations Committee of the Detroit Police Department. He was a contributor to the African Art Gallery of the Detroit Institute of Arts and established an annual scholarship at the University of Windsor. He founded and managed two hospitals in Detroit.

OFFER BIBLIOGRAPHY ON EMERGENCY SERVICES

A list of folders and booklets has been compiled by the Michigan State Medical Society which deal with emergency medical care and emergency ambulance service.

These publications, which will be of great assistance to staff persons, are available for the asking. The list can be obtained by writing PR Committee, MSMS, P.O. Box 152, East Lansing, Mich.

Building, Clinic, Practice For Sale

The clinic and practice together with medical equipment covering eleven (11) offices as well as accounts receivables of the late Dr. Leo B. Saraf. The highest offer will be accepted.

Contact in writing:

Dr. V. P. Moisides, Executor
1205 Mutual Building,
Detroit, Michigan

or

Irving B. Ackerman,
Attorney for Executor,
1665 Guardian Building
Detroit, Michigan

WSU GETS GRANT

A U. S. Public Health Service grant of $85,919 will be used to continue studies of protein synthesis in heart muscle, directed by Richard J. Bing, M.D., Birmingham, professor and chairman of internal medicine at Wayne State University.

MICHIGAN FIRM SELLS DIAPER ANTIBIOTIC SPRAY

For the past three years, several Detroit and Jackson physicians have been testing a new diaper antibiotic. Approved in January of this year for over-the-counter sale by the FDA, the testing program was correlated by Ethan L. Stone, M.D., medical director of DaRoche Laboratories, Inc.

The antibiotic is a neomycin sulphate aerosal spray which is used for the prevention of ammonia diaper and diaper odors.

Called "Dapper Diaper," the new product is being manufactured by DaRoche Laboratories in Jackson. Vice-President of the corporation is John B. Holst, M.D., a Jackson allergist. Doctor Holst reports the new antibiotic is helpful in both pediatric and geriatric practice. Physician samples can be obtained from DaRoche Laboratories, at 533 Hupp, in Jackson. ☐

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
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Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:

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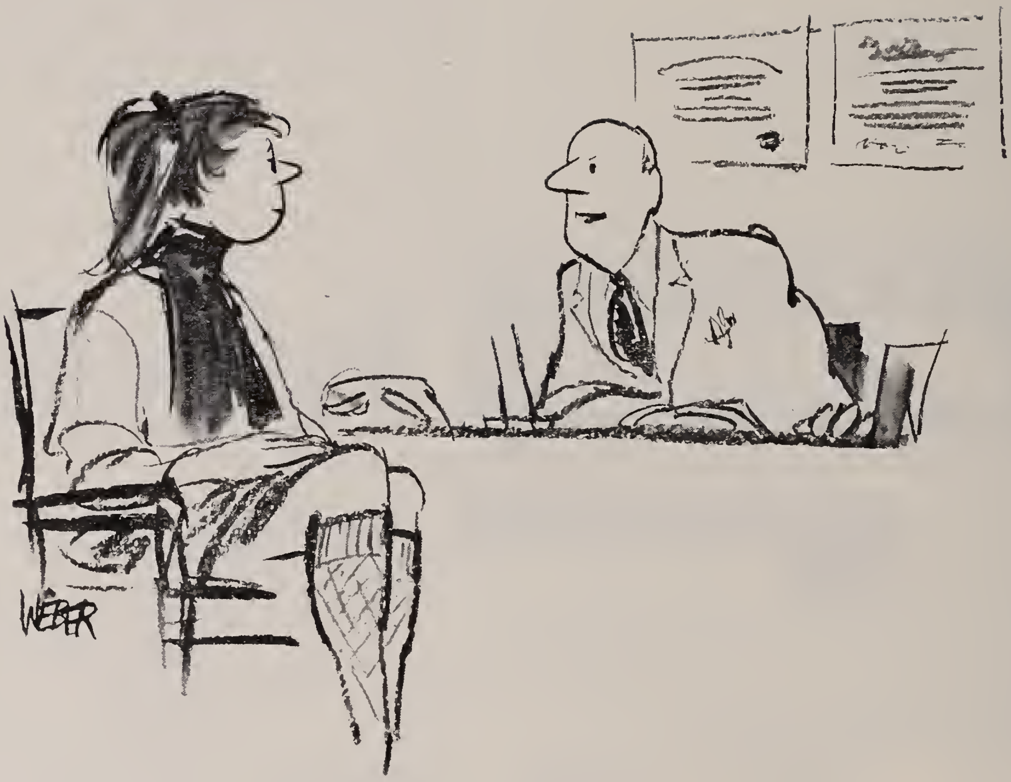

"Now that your acne is clearing up nicely, it might be a good idea if you started losing some weight."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Dextro-Amphetamine Sulfate (15 mg.)
with Meprobamate (300 mg.)

Sustained Release Capsules

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WANTED: Internist to join 2-man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D., or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

BUSY GP retiring to Administration own Detroit hospital. Full income to you during introduction. Modern home combined with fully equipped offices. Nothing down, long terms for less than real estate alone. No doctors within 10 blocks. Three new grade schools within three blocks. Fantastic nondiscriminatory opportunity. Phone (313) 868-1401.

DUCK HUNTERS ATTENTION: I am a registered duck guide and am now offering guide service on Northwest Saginaw Bay where there is lower hunting pressure, more ducks, better shooting. Decoys, boats and blinds provided. Write for free pictured brochure and news letter. John Pestrue, Standish, Michigan 48658.

PSYCHIATRIC RESIDENCIES: NIMH stipends of $12,000 per year available for our approved three-year, community oriented dynamic program in Metropolitan Detroit area. University associations. Teaching staff of Board men, psychoanalysts, outstanding visiting lecturers. Active research. Modern physical plant. Physicians completed internship four years ago are eligibile. Contact: Calvin H. Chen, M.D., Director of Education and Research, Northville State Hospital, 41001 Seven Mile Road, Northville, Michigan 48167.

GENERALIST as a member of Medical Staff of Progressive State Hospital in Michigan's Vacationland. Hospital has three-year accreditation, JCAH and three-year residency accreditation by A.P.A. Salary $17,867.20 to $21,777.60. Excellent fringe benefits. Civil Service security when qualified. Apply L. B. Young, M.D., Director of Medical Services, Traverse City State Hospital, Traverse City, Michigan 49684.

MEDICAL DIRECTOR: Single County Health Department. Population approximately 165,000. Department employs approximately 45. General Health programs. Excellent relationship with physicians' groups. Outstanding year round recreational activities. Excellent schools. Desire M.D., M.P.H.; will consider M.D. willing to obtain M.P.H. with assistance, within three years of employment. Location Western Michigan. Salary open, in excess of $21,000, depending on qualifications and Experience. Many fringe benefits. Send resume to James V. Wells, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

WANTED: ORTHOPEDIC SURGEON, board certified or eligible to join two-man partnership. Very active widely varied practice. Two fully equipped hospitals. Town of 40,000 on Lake Huron, fifty minutes from downtown Detroit. Excellent living, sailing, recreational area. Starting salary up to $30,000. Association thereafter. Write C. O. Townley, M.D., or S. C. Walker, M.D., 1209 Tenth Street, Port Huron, Michigan 48060 or call collect (313) 982-9923.

WANTED: Family practitioner to associate with two younger physicians to form a three-man group in Essexville, Michigan. Losing one physician to industry, is reason for need. Lovely residential office and excellent community. Contact: Dr. Arlyn Moeller, M.D., Essexville Medical Building, Essexville, Michigan 48732.

WANTED: INTERNIST for small group in Fox River Valley. Recreational center with emphasis on fishing and boating. Newly remodeled 400 bed hospital. Salary with partnership opportunity after first year. Begin 1969. Contact Dr. V. G. Guenther, 417 Mt. Vernon St., Oshkosh, Wisconsin 54901.

WANTED: General Practitioners, Internist, and Pediatrician to practice in modern building. Good opportunity for young man coming out of service. Allen Medical Building, Bay City, Michigan 48706.

PHYSICIAN for full or part time work, weekends, vacations, etc., in G.P. office. Ann Arbor area. Hours flexible. Michigan license necessary. Reply Box #14, 120 West Saginaw, East Lansing, Michigan 48823.

STAFF PSYCHIATRIST — Competent, with 3 years approved residency training for progressive Community Mental Health Center serving county of 60,000. Salary up to $25,000 annually, depending on qualifications. Analytically oriented psycho-therapy, drug therapy, marriage counseling and consultations with local agencies. Ideal location in heart of Michigan, with quick access to every major city; excellent schools and churches, and community activities. Michigan license required. Write or Phone: Director, Shiawassee County Mental Health Center, 826 W. King, P.O. Box 302, Owosso, Michigan 48867 Tele: (Code 517) 723-5285 or 5286.

GENERAL PRACTITIONER with surgical experience desires to relocate in Michigan, leading to possible permanent association. Currently available, Michigan license. Reply Box 16, 120 West Saginaw, East Lansing, Michigan 48823.

TWO G.P.'s Desire a third G.P. as an associate in Flint, Michigan. Must be young, ambitious and thorough with above average capabilities. Practice is unique and the income considerably above average. Reply: Box 15, 120 W. Saginaw Street, East Lansing, Michigan 48823.

FERRIS STATE COLLEGE needs two additional full time staff Doctors for Student Health Center. Thirty-one bed Infirmary and enlarged out-patient facility ready this fall. Excellent opportunity for qualified persons in small quiet college town. Regular hours with rotating night and weekend call. Salary to $18,000 and excellent fringe benefits. Please contact Roy A. Davis, M.D., Area (616) 796-8463 or write in care of Ferris State College, Health Center, Big Rapids, Michigan 49307.

ANESTHESIOLOGIST — Position available for a Board Certified or eligible in a 200-bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from $19,206 to $23,075. Excellent fringe benefits. Must be licensed in a State, Territory, or Commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact: Chief of Staff, Veterans Administration Hospital, Fort Wayne, Indiana 46805.

INTERNIST — Position available for a Board Certified or eligible in a 200-bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from $19,206 to $23,075. Excellent fringe benefits. Must be licensed to practice in a State, Territory, or Commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Indiana 46805.

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.

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VOLUME 67, NUMBER 19
OCTOBER, 1968

AMONG THE EXCELLENT ARTICLES INSIDE:
- —GENETIC FACTORS IN PHYSICAL GROWTH AND DEVELOPMENT
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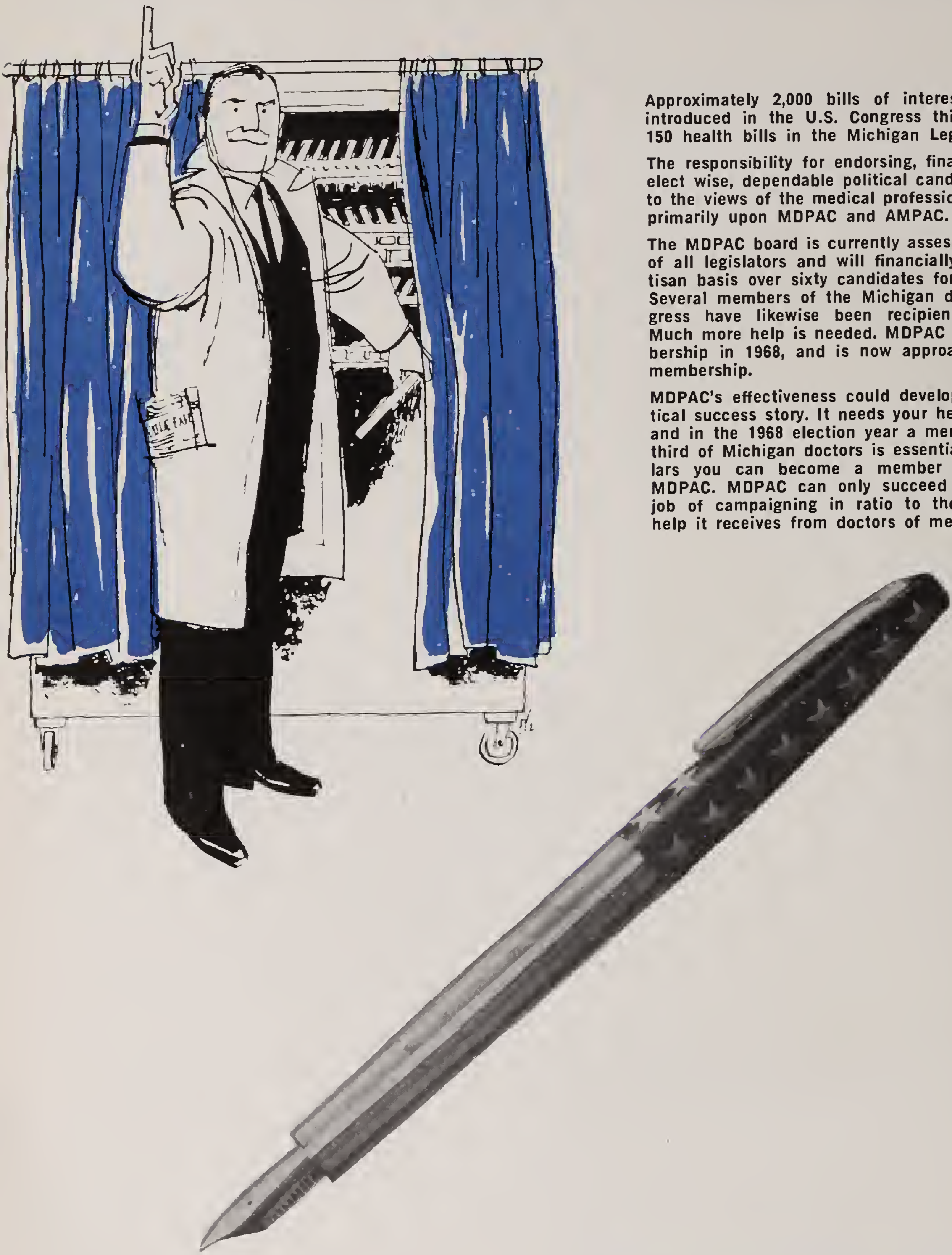

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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THE COVER

This month the cover recognizes Marjorie Peebles Meyers, M.D., who was selected by the 1968 House of Delegates as the "Outstanding Physician of the Year." See pages 1243, 1244, and 1245 for additional photographs and a feature article.

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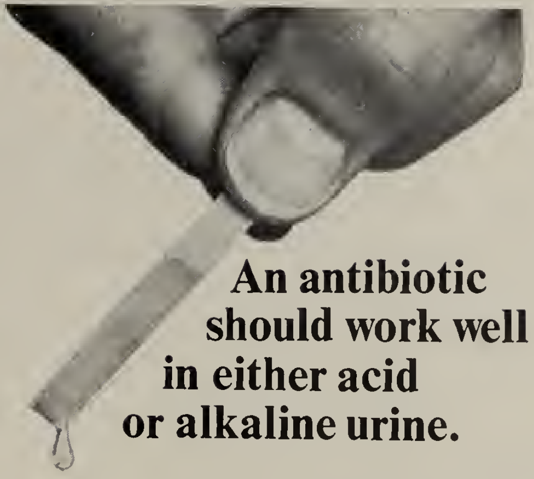

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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MSMS PRESIDENT'S MESSAGE

Observations about Complications

The changing of the guard has again been accomplished and as your President for the next twelve months it will be my privilege, honor and pleasant duty to present a monthly page or two of delectable composition concerning computerized health and other matters of mutual concern in these United States and particularly in our own state of Michigan.

The understatement of the year is that — "the practice of medicine is changing rapidly and is becoming much more complicated" — as anyone who is in anyway associated with the direct care of patients in or out of hospitals, knows — but actually these incessant changes in medical practice, started many years ago with the introduction of health insurance in all of it's forms. Don't blame Medicare and Medicaid for all of the difficulties one encounters in medical practice today. All that these programs have done is to add a few more frustrating daily experiences to your already heavy load of past frustrations.

UNFORTUNATELY, ALONG with this great influx of new complicated printed forms and new rules and regulations of hospital medical practice, there has already appeared on the horizon the philosophy of depersonalization of the patient-physician relationship — mainly because physicians cannot possibly spend the time as they used to — listening patiently to the complaints of people and trying to figure out whether the complaints are based on physical defects or psychosomatic symptoms of a functional or emotional nature.

There is no substitute for the face to face confrontation of the patient with a physician and the computerized analysis of symptoms followed by a quick view of the patient on direct hospital or office television cannot possibly give the patient anything but a feeling of insecurity.

THE PROBLEM, OF COURSE, revolves around two facts — the increasing number of people demanding medical care and the decreasing number of physicians to service those patients who have specific physical complaints or who are looking to someone for a "checkup." About 70% of patients seen in routine office practice, do not have a physical basis for their symptoms — but if the philosophy of preventive medicine is to be continued, it will be necessary for someone to examine these people to detect latent disease or possible early malignancy.

We are without question entering a new era in which the long established and very personal relationship between patient and Doctor is in jeopardy. Modern medicine is broadly based with a variety of specialists, both professional and nonprofessional trying to co-operate in the care of a single patient. In most instances an outside agency pays the bill. How, in this complex relationship we are to preserve some semblence of stability, should be a matter of deep concern to all of us.

ANOTHER DISQUIETING thought that will cause a further shortage of physicians, is the fact that Doctors are now retiring at an earlier age because of overwork or because of physical ailments, brought on by overwork. Various types of so-called "Group Practice" are developing to alleviate some of the problems previously associated with solo practice, so that group responsibility may lessen the physican strain and drain on individual practitioners.

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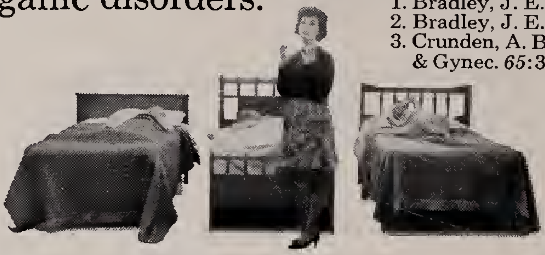
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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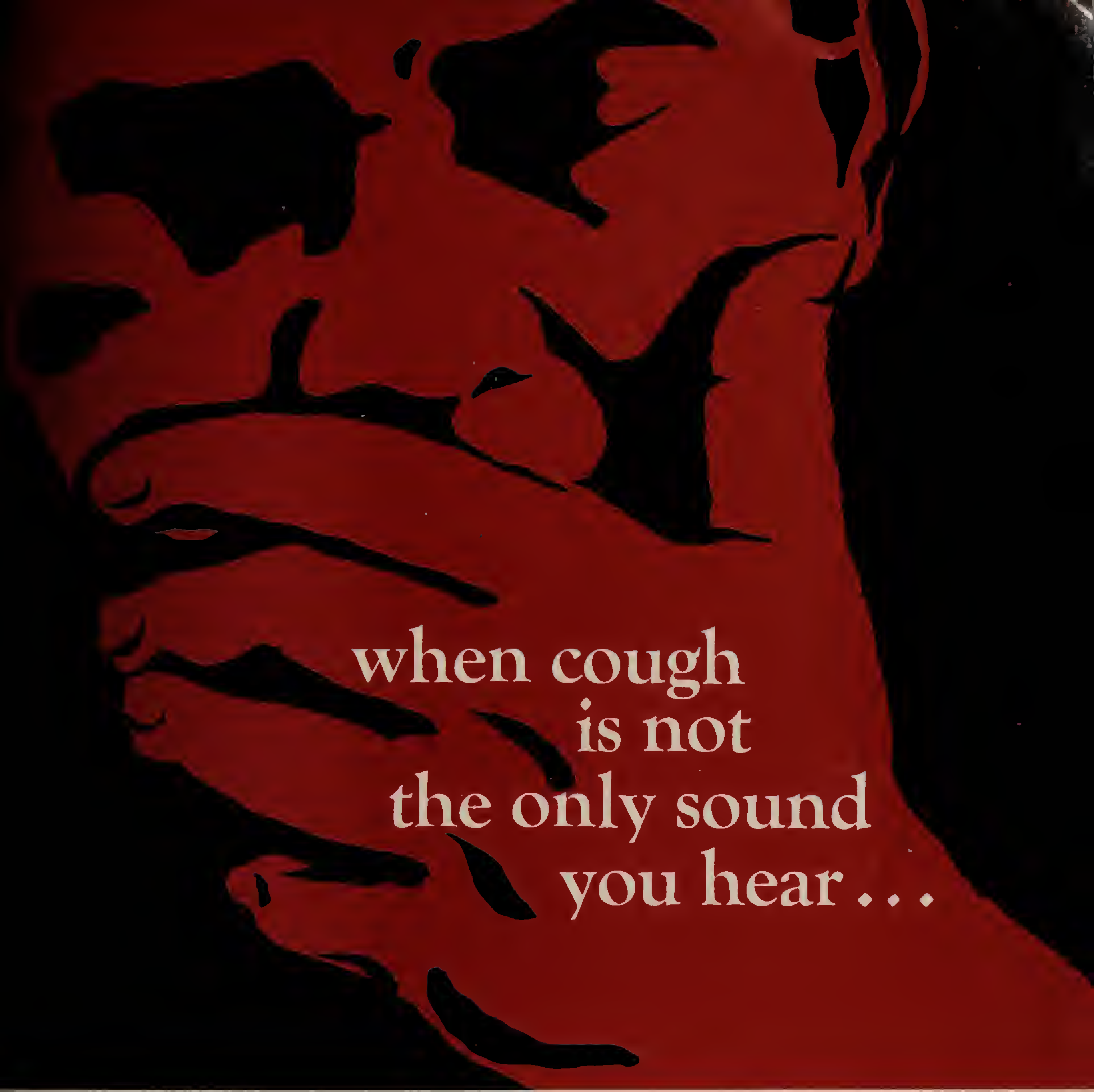

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-

BENADRYL in '68

choose an experienced candidate–
millions of doses prescribed

Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968

No two women are quite alike...

Ovulen-21 Com
Directions

and no other oral contraceptive is quite like Ovulen-*21*®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. *2*:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. *2*:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

"Breathing's a snap again," he said gingerly.
(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A-H-ROBINS

in sinusitis, colds, U.R.I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

KEFLIN®
SODIUM
CEPHALOTHIN
4 Gm.

on call...

Keflin®
Sodium
Cephalothin

Eli Lilly and Company
Indianapolis, Indiana 46206

“The inconvenience of a cold”

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis – or to help prevent the acute condition from becoming chronic.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

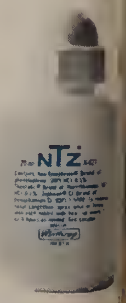
NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

Winthrop Laboratories, New York, N.Y. 10016 Winthr



Dilantin®
(diphenylhydantoin)
PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road   Conducted by Sisters of Mercy   Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

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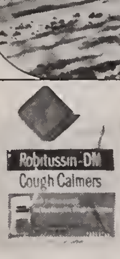
* 1904 - 1967

BETTMAN ARCHIVE
Gotta make a pit stop to take my cough syrup.
Full speed ahead, Fred. These solid Cough Calmers can control that cough for 6 to 8 hours.
2



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Tuberculosis? Influenza?
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Systemic Fungal Diseases?
Chronic Chest Diseases?
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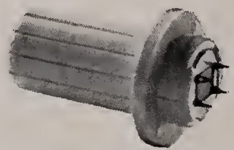
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Is it depression?

He says "It's my stomach..."

...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt
strongly suggest
an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MSD **MERCK SHARP & DOHME** Division of Merck & Co Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Knee-deep

TA-6006

in osteoarthritic pain

If aspirin doesn't help, move in ith Tandearil.

The trial period is brief: 1 week. y one tablet q.i.d. at first. Tandearil sually starts working within 3 to 4 days. hen response occurs, as little as 1 or ablets daily may hold back pain and ffness, and increase joint motion.

On the next page is a summary adverse reactions, contraindications, arning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

idearil, oxyphenbutazone:
brief summary see next page.

Geigy

TA-6006

Tandearil®

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis:
Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

in the treatment of

IMPOTENCE

Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY

ANDROID GOOD TO EXCELLENT 75%

PLACEBO 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.

Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**. One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens. hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

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Specialized Service

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is a high mark of distinction

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“All Registered Nurses are Alike”

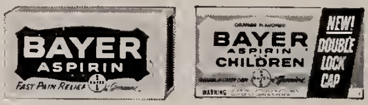
It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That’s nonsense, of course. But it’s no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer’s standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn’t so.

You might also say that all registered nurses aren’t alike, either.



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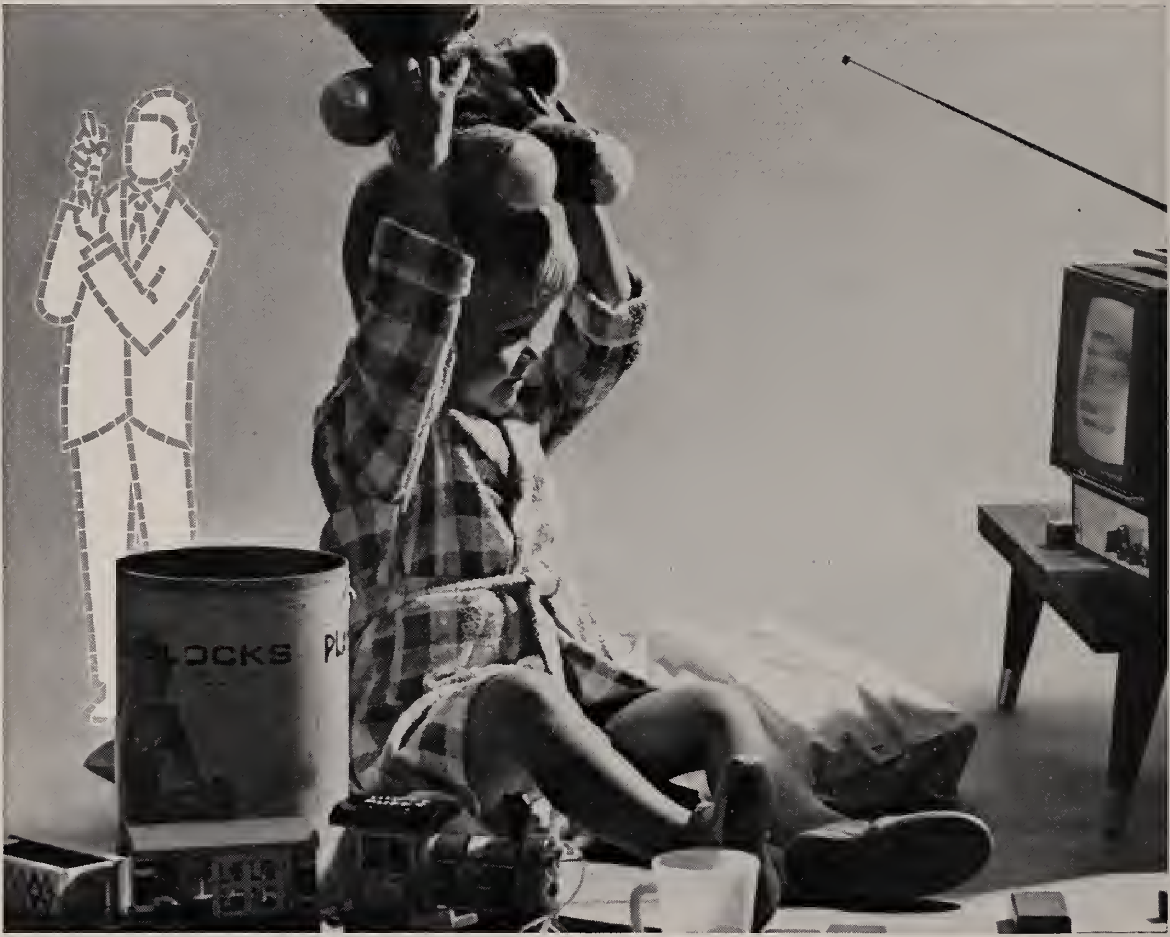

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Genetic Factors In Physical Growth and Development

BY JOHN C. GALL, JR., M.D.
DETROIT

INTRODUCTION

The observation that "like begets like" was probably one of the earliest scientific observations made by man. As applied to human growth and development, the influence of heredity is most striking in those conditions characterized by pathological growth, whether excessive (giantism) or inadequate (dwarfism).

PATHOLOGICAL GROWTH

DISORDERS DUE TO SINGLE GENES

Dwarfism. Obviously, many diseases can cause stunted growth, and a number of these are determined by single genes. The basic defect may be a disturbance of bone, a hormonal disorder, or an abnormality of cellular metabolism. An example, known from ancient times, is achondroplastic dwarfism. In this condition, which is due to an autosomal dominant gene, a disturbance of bone growth results in abnormally short bones of the extremities producing a very short individual with characteristic bodily proportions. Ancient Egyptian sculptures clearly portray the short arms and legs, the normal-size trunk and the relatively large head which is commonly somewhat hydrocephalic.[1] Although the condition does not result in sterility, relatively few achondroplastics produce offspring. Thus most cases are due to new mutations. There is usually no impairment of intelligence. A brilliant contemporary actor, who played the dwarf in the movie "Ship of Fools," is an achondroplastic.

The recognition of genetically determined syndromes associated with shortness of stature is important clinically, both in terms of adequate treatment and for purposes of genetic counseling. A very practical approach to the clinical evaluation of the short child has recently appeared in this Journal.[2] A useful (though not exhaustive) Compendium on Shortness of Stature, listing over 50 syndromes, many of them genetically determined, has recently been published.[3] Tables 1 - 3 list some of the genetically-determined conditions associated with impaired growth.

Giantism. Among the famous giants of history were the champion of the Philistines, Goliath, and the Roman Emperor Maximinus (172-238 A.D.), whose main claim to imperial power appears to have been his enormous stature, estimated by contemporaries at about eight feet. We are not certain of the diagnosis in either case. Perhaps the most common single-gene cause of giantism is Marfan's syndrome, sometimes called arachnodactyly because of the long spidery arms and legs present in most cases. The complete picture includes eye defects, in particular dislocated lenses, and cardiovascular abnormalities, most notably a tendency to develop aortic aneurysm. The basic defect, which is probably in the structural protein of connective tissue, may be the cause of overgrowth of the long bones.

It has been postulated that President Abraham Lincoln may have had Marfan's syndrome.[4] He was 6-4 and had a longer reach than any soldier in the Union Army. Many observers at the time noticed and commented on his long arms and legs, actually using the word "spidery" to describe them, and his official sculptor was impressed by the huge size and proportions of his hands. Just recently, several members of the Lincoln family have been definitely diagnosed as having Marfan's syndrome. This single dominant gene has apparently been transmitted through 8 or 9 generations.

CHROMOSOMAL ABNORMALITIES

Chromosomal abnormalities have very pronounced effects on growth and development.

Autosomal effects. Trisomy-21, Down's syndrome, or mongolism, is a classic example. Children with Down's syndrome, in addition to being mentally very slow, are quite small. At birth their size is close to normal, but within a year or two they have fallen significantly behind and tend to remain well below the tenth percentile throughout childhood.

THE AUTHOR

Doctor Gall is assistant professor, department of pediatrics and communicable diseases and research associate, department of medicine (Simpson Memorial Institute), University of Michigan Medical Center; and also medical geneticist, Plymouth State Home and Training School, Northville.

TABLE I

Some single gene conditions associated with impaired growth.

SINGLE-GENE DEFECTS	
AUTOSOMAL	SEX-LINKED
Recessive	
Isolated HGH deficiency	Menkes' syndrome (kinky-hair disease)
Fanconi's syndrome (pancytopenia with multiple anomalies)	Hunter form of mucopolysaccharidosis
Bloom's syndrome (telangiectatic erythema)	
Ataxia-telangiectasia	
Ellis-van Creveld syndrome (chondroectodermal dysplasia)	
Morquio's syndrome	
Hurler's syndrome (mucopolysaccharidosis)	
Cartilage-hair hypoplasia	
Hypophosphatasia	
Some forms of cretinism[12]	
Familial aldosterone deficiency[13]	
Cystic fibrosis	
Dominant	
Achondroplasia	Albright's osteodystrophy
Cleidocranial dysostosis	Hypophosphatemic rickets (pseudohypoparathyroidism)
Osteogenesis imperfecta	

Tables compiled mainly from Smith, D. W.[3]

TABLE II

Some chromosomal abnormalities associated with impaired growth.

CHROMOSOMAL ABNORMALITIES	
AUTOSOMES	SEX CHROMOSOMES
Mongolism	Turner's syndrome (XO)
18-trisomy	XXXXY syndrome
Cri-du-chat syndrome	

Tables compiled mainly from Smith, D. W.[3]

TABLE III

Some conditions associated with impaired growth for which a genetic basis has not been definitely established.

GENETIC BASIS DOUBTFUL

Prader-Willi syndrome (mental retardation, obesity, cryptorchidism)
Smith-Lemli-Opitz syndrome (retardation, microcephaly, multiple minor anomalies)
DeLange syndrome (microcephaly, micromelia, synophrys)
Hallermann-Streiff syndrome (birdlike facies, atrophic skin, thin hair)
Seckel syndrome (bird-headed dwarfs)
Silver syndrome (skeletal asymmetry, cafe-au-lait spots)
Dubowitz syndrome (low-set ears, peculiar facies, and eczema)
Rubinstein-Taybi syndrome (broad thumbs and toes, mental retardation and unusual facies with beak-like nose)
Progeria (Hutchinson-Guilford Disease)
Leprechaunism

Tables compiled mainly from Smith, D. W.[3]

Figure 1 shows growth curves for a group of mongoloid children at Plymouth State Home in Northville.[5] It is interesting to note that those who are cared for at home do somewhat better, consistently, than those who were left in the institution at an early age.

Another autosomal abnormality that results in impaired growth is trisomy-18. However, since this condition is almost always lethal within the first year of life, slow growth is a relatively minor problem.

Sex Chromosomal Effects. A large number of sex chromosomal abnormalities are now known. If these are compared according to the presence or

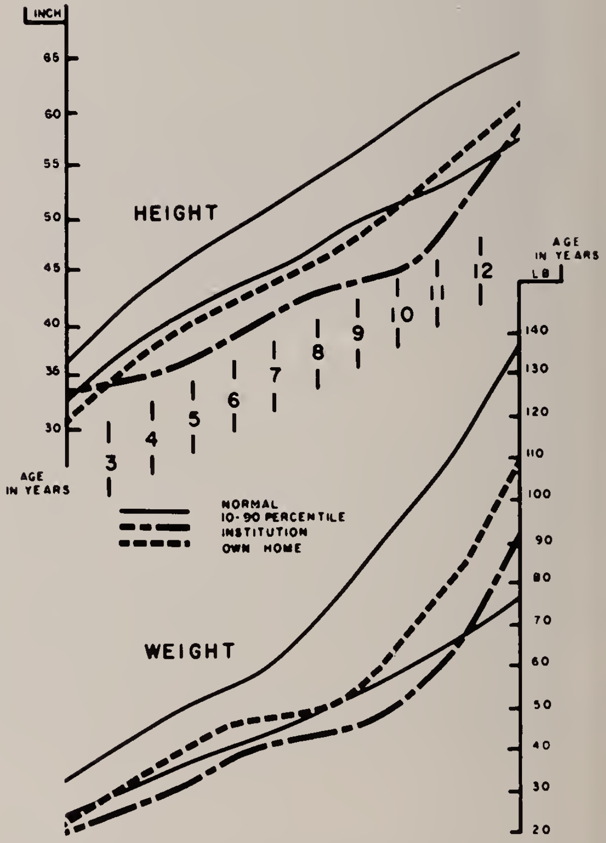

FIG. 1. Growth curves of 25 Mongoloids Raised at Home (dotted lines) and 40 Mongoloids Institutionalized in Infancy (dashed lines). The Solid lines represent the 10th and 90th percentiles for Normal Children.

absence of one or more Y chromosomes, an interesting fact appears. The Y chromosome seems to confer added stature.[6] Children with Turner's syndrome (XO chromosome constitution) are abnormally short. The XYY male is often over six feet tall. For some unknown reason, the XYY male also seems to be rather aggressive, and several cases have been found by looking in the wards of the criminally insane for very tall individuals.[7]

NORMAL GROWTH

Polygenic Basis of Stature in Man. The genetic element in the determination of normal growth and development has been obvious down through the ages. Men have always recognized that small parents tend to have small children and tall parents tend to have tall children. However, this common observation was first put on a scientific basis earlier in this century by R. A. Fischer, who worked out the degrees of correlation in size between relatives that would be expected on the assumption of multifactorial Mendelian inheritance.[8] His calculations, which were based on a group of people with a very homogeneous background, tended to underestimate the importance of environmental factors such as adequate nutrition. Later studies[9] have suggested that environmental factors may account for a significant proportion of the variation in human stature. However, the hereditary factor is of preponderant importance, especially in advanced countries.

An additional complication in regard to human size is the existence of a pronounced maternal effect. Small mothers tend in general to have smaller babies regardless of the genetic factors involved. Parental influence on stature has been studied by Garn and others, who have compiled individualized tables of expected normal height and weight based on the sizes of the parents.[6] These provide a more accurate prediction of expected stature than standard height-weight tables.

Biochemical genetic factors. For some reason, there has been a lack of research on the subject of biochemical genetic factors in normal growth. One reason for this lack of research perhaps is the belief that growth is primarily determined by levels of human pituitary growth hormone (HGH), which, until recently, could not be assayed satisfactorily. The availability of assay methods for HGH opens up new fields for investigation of persons with abnormally great or small size, but it is still not known whether growth hormone levels are the primary determinants of stature within the normal range.

Isolated HGH deficiency. One especially interesting result of the availability of assay methods for human growth hormone has been in relation to a rare form of dwarfism known as sexual ateliotic dwarfism. In this condition, birth weight is normal but growth is very slow. Puberty does occur but may be delayed up to 25 years of age. Adult height of affected persons is well under 5 feet. There is no deficiency of TSH, FSH, or ACTH, but McKusick and his colleagues have shown that affected persons are almost completely deficient in human growth hormone.[10] The condition shows an autosomal recessive pattern of inheritance. In one of the families reported by McKusick, two affected parents produced an affected child whose birth weight was normal. This interesting experiment of nature demonstrates that intrauterine growth is apparently not under the primary control of either fetal or maternal growth hormone.

Bodily proportions — Obesity. Growth includes not only total body size and stature, but many additional elements for example, bodily proportions that distinguish tall, thin people from short, stocky ones; relative head size; and amount of body fat. Marfan's syndrome, as we have seen, is a good example of a genetic determinant of a long, lanky body type. Obesity is a more complex problem, since almost everyone has the capacity to become obese given the right combination of underexercise and overeating. However, certain genetically determined conditions are regularly associated with some types of obesity. An example is the Laurence-Moon-Biedle type of mental retardation. Children with mongolism are short and often have a roly-poly appearance.

Special Organs. The growth and shape of the eyes and the teeth are under very strong hereditary control. The story in relation to the eye is particularly interesting, as a recent study[11] suggests that eye measurements, such as the distance from cornea to retina, are almost entirely under genetic control and only minimally influenced by environment (with the exception of course, of destructive eye diseases and direct trauma). It is easy to see in a teleological sense why this is so, since a reasonable degree of visual acuity is absolutely essential for survival under primitive conditions; and this could not be maintained if the dimensions of the eye were subject to large fluctuations determined by environment.

Ethnic genetic factors. There are also racial differences in body size. Although these are to some extent due to the nutritional and other environmental circumstances under which different racial groups live, there is no doubt that genetic factors play a large part. The bodily proportions of the Watutsi, for example, many of whom are over seven feet tall, are genetically determined. The pygmies are genetically small. However, it must be stressed that the body chemistry of such groups has not been adequately studied to see to what extent differences in body size can be accounted for on the basis of known factors.

These, however, are questions for the human biologist rather than the clinical physician. The physician is primarily concerned with pathological growth, and in particular with the child who is too small. Such a child may have a disease that is preventing him from growing. It is up to the clinician to make the diagnosis and begin the proper treatment. An awareness of genetic factors and of inherited syndromes can be of assistance in this respect.

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Effects of Early Institutionalization On Growth and Development of Young Children with Down's Syndrome

ABSTRACT: Physical growth as well as motor and mental development of 40 children with Down's Syndrome who were institutionalized in infancy is compared to that of 25 similar children reared by their own parents.

All children are now ages 4-12 years old, have G-trisomy on karyotype analysis, had mongoloid features in infancy and similar birth weights. On the basis of this study and others it is apparent that parents of mongoloid infants should be told that most children with Down's Syndrome will become independent in such self-care areas as walking, talking, eating and toileting by the age of 6; that they will be accepted by day-care centers and special classes in public schools; and that they will attain higher levels of achievement, especially in speech, if they are not institutionalized at an early age.

However, the child with a physical defect which is incapacitating or incompatible with longevity might well be institutionalized if the parents so desire. Parents who elect to maintain their mongoloid child at home deserve their physician's support, encouragement and guidance.

The three co-authors are associated in the Research Department of the Plymouth State Home and the Training School at Northville.

BY CYRUS W. STIMSON, M.D.
ROBERT GEAKE, Ph.D.
HOMER WEIR, M.D.
NORTHVILLE AND PLYMOUTH

By the time they are six years old, most children with Down's Syndrome are capable of walking independently, communicating effectively and caring for most of their personal needs. Communities throughout the nation have established day-care centers and special classes for such children in public schools. Nevertheless, many physicians continue to give parents a feeling of utter hopelessness when they produce a mongoloid child and then advise immediate institutionalization. That such a procedure produces deleterious effects on growth and development of young children has previously been reported.[1-4]

We relate in this article our own observations of 65 children, who are now 4-12 years old, with Down's Syndrome. Forty were institutionalized during infancy and have resided there ever since. Twenty-five are being reared in their own homes by their parents. Twenty children in this latter group are now in day-care centers or public schools.

According to Carter,[5] there are infants with most of the physical stigmata of Down's Syndrome who do not have typical G-trisomy and who in later years have normal intelligence. Early institutionalization of such infants would only lead to iatrogenic mental deficiency. Cytogenetic studies[6,7] are essential to establish the diagnosis of mongolism before institutional placement is considered. The children whose development is reported in this study all have G-trisomy.

METHODS

Among the 200 mongoloid children now in residence at Plymouth State Home and Training School, 40 were found who were admitted to a nursing home or institution during the first year of life and who are now 6-12 years old. These children have been weighed and measured at monthly intervals throughout life and developmental milestones were recorded in the form of progress notes as the children attained them. The 25 children being reared in their own homes have all been evaluated in the out-patient clinic at Plymouth State Home. From our own observations of these children during their visits and from their histories obtained from their parents, it was possible to derive similar measures on members of this group.

Eight measures of growth and development were considered: (1) height and (2) weight as recorded at two year intervals; ages at which patient first (3) walked independently, (4) talked effectively, (5) fed himself with a spoon and (6) became completely toilet trained. Our psychologists determined an intelligence quotient (IQ) using the revised form of the Stanford-Binet and the Wechsler Intelligence Scale for children, and a social quotient (SQ) using the Vineland Scale of Social Maturity for each of the 65 children. The IQ and SQ scores represent measures number 7 and 8.

A simple one-way analysis of variance test was used to determine whether there were any significant differences between the two groups on each of the eight measures. Chromosome studies indicate that all patients have G-trisomy. No patient with normal karyotypes, mosaicism or translocation were considered in this study.

RESULTS

The results are summarized graphically in charts 1 and 2, and the mean values are given in tables I, II and III. The mean IQ and SQ scores for 40 institutionalized children with Down's Syndrome were 17.6 and 29.5, resp., compared to 35.6 and 54.2 for similar children reared at home. These

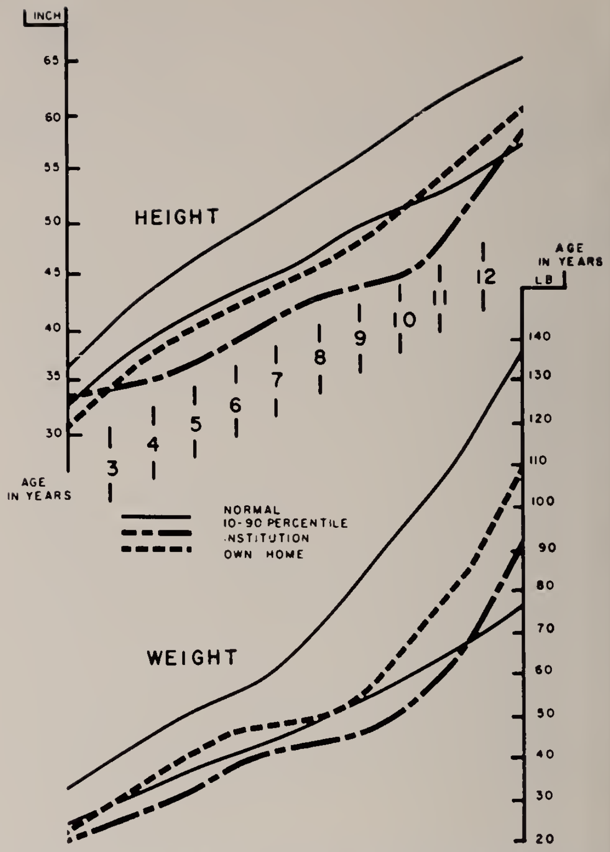

CHART II: Physical growth of institutionalized and non-institutionalized groups of children with Down's Syndrome compared to normal children.

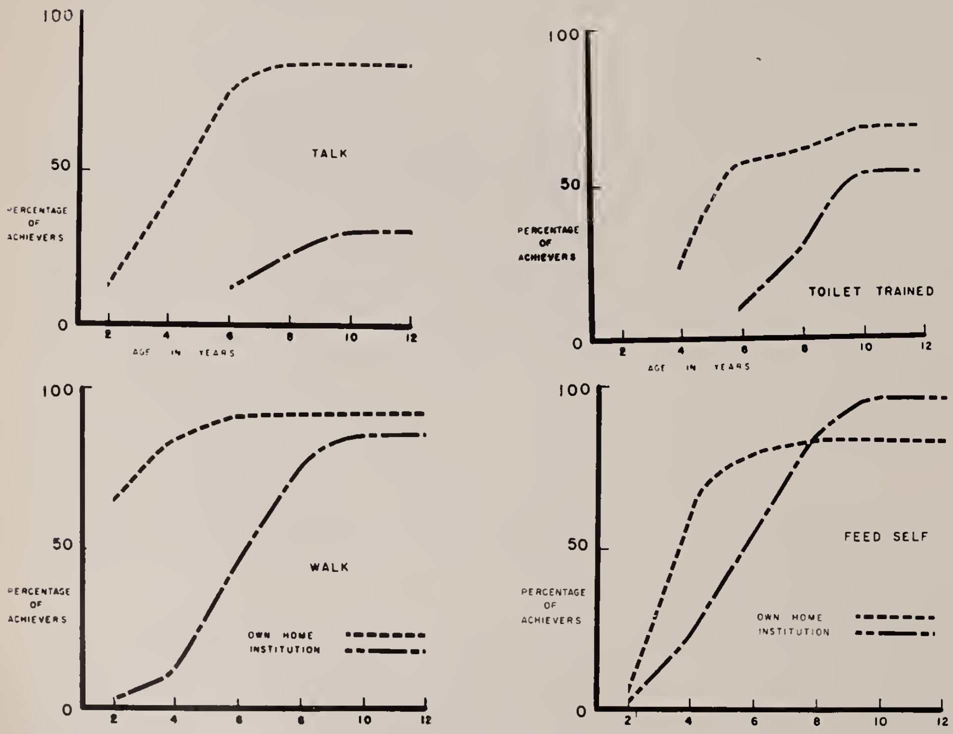

CHART I: Ages at which institutionalized and non-institutionalized children with Down's Syndrome attained four important developmental milestones.

scores reflect the effects of intellectual stimulation, training and experience as well as innate capabilities to learn. The institutionalized children learned to walk independently and feed themselves at a mean age of just over 6 years whereas their fellows reared at home accomplished these at mean ages of 3 for walking and 4 for self feeding. Twenty-one of 40 institutionalized children are toilet trained and they accomplished this at 8 years; sixteen of 25 children living at home completed this training at a mean age of 5 years. Only 10 of 40 institutionalized children are talking effectively and they did not accomplish this until a mean age of 7.8 years. Twenty-one of the 25 children living at home are talking effectively and this was accomplished at a mean age of 4 years. All of these differences are significant at the .01 level.

In general, heights and weights of patients in both groups remain at about the third percentile until age 8 years; they then increase to reach the 25th percentile at age 12 (graph 2). Analysis of variance reveals no significant differences in either height or weight between the two groups. Apparently institutionalization has not produced an effect on physical growth of the 40 children considered in this study. Up to and including age 8 years, our children are similar to those reported by Thelander and Pryor;[8] however, our values for ages 10 and 12 are higher than theirs. Only

TABLE I

Mean Developmental Measures for Institutionalized Mongoloids And Those Living in Their Own Homes

	Institutionalized	Home	Difference *
IQ	17.6	35.6	18.0
SQ	29.5	54.2	24.7
Age Walked (yrs.)	6.31	2.64	3.67
Age Fed Self (yrs.)	6.13	4.26	1.87
Age Toilet Trained (yrs.)	8.57	5.00	3.57
Age Talked (yrs.)	7.80	4.05	3.75

* All differences significant beyond the .01 level

TABLE II

Mean Growth Measures for Institutionalized Mongoloids And Those Living in Their Own Homes

Height	Institutionalized	Home	Difference *
2 years	29.4 inches	29.7	0.3
4 years	34.3	37	2.7
6 years	37.6	41.5	3.9
8 years	42.8	45	2.2
10 years	44.4	51.5	7.1
12 years	54	57.8	3.8
Weight			
2 years	19.1 pounds	21	1.9
4 years	26	34	8.0
6 years	32.7	45.3	12.6
8 years	41.4	45.7	4.3
10 years	48.9	64.0	15.1
12 years	72.7	90.8	18.1

* Differences are not significant

TABLE III

Mean Values of Other Variables for Institutionalized Mongoloids And Those Living in Their Own Homes

	Institutionalized (N = 40)	Home (N = 25)	Differences *
Year Born	1958	1959	1 year
Birth Weight	6.78 lbs.	6.38 lbs.	0.4 lbs.
Ratio Males: Females	18:22	17:8	
Other defects	10 (25%)	4 (16%)	(9%)

* Differences are not significant

eight of the patients considered in our study have attained the age of 12 years while 16 have reached the age of 10. While this small number of cases allows comparison of the institutionalized to the non-institutionalized groups of patients at these ages, the number is insufficient to conclude that the height and weight of mongoloid children approaches normal values at age 12 years as suggested by the graph.

Other variables, including year of birth, birth weight, sex and presence or absence of other defects, were considered to determine whether the patients constituting the two groups were similar. The available data indicates that they were (table III).

DISCUSSION

When parents receive the shattering news that their offspring is afflicted with Down's Syndrome, one of their first questions is "Should we take the child home with us?" In the past, physicians have often advised the parents to place the child immediately in a nursing home or institution and try to forget it, and even to tell the other children and relatives that the child died! Such a procedure is detremental to the child and parents alike. We have never encountered parents who were able to forget. Those parents who did follow this procedure developed strong guilt feelings which were often more harmful to the marriage and other children than the presence of the afflicted child in the home would have been.

We realize that some families would not survive with a mongoloid child in the home and endorse the philosophy of Birch and Belmont[9] that antiplacement rigidity is no sounder than proplacement stereotype as a basis for the early management of mentally defective children. We feel that the following procedure is sound whenever parents and their physician are considering the placement of a mongoloid infant in an institution for the mentally retarded.

1) Cytogenetic studies are done to substantiate the diagnosis. Children with normal karyotypes, mosaicism and even translocation should not be institutionalized, on the basis of mongoloid features, unless at age four or five years they are found to be severely retarded.

2) The parents are told that (a) most children with Down's Syndrome will be able to walk, talk, feed and dress themselves and become toilet trained by the time they are six years old and that day-care centers and special classes in public schools are accepting such children. As small children, mongoloids present the same problems of care that normal children do. While it is true that children with Down's Syndrome are susceptible to respiratory and skin infections, such infections respond well to medical treatment. Unless the infant has a symptomatic heart defect or other incapacitating congenital anomaly, his care will be very similar to that of normal babies. (b) If the afflicted child is raised in his own home his motor and mental development will be closer to normal than if he were raised in an institution. The average IQ of school-aged children with Down's Syndrome who are raised in their own homes is 40 compared to 20 in institutionalized cases. Thus, for the good of the afflicted child, parents are urged to maintain the infant at home at least until he is 6 or 7 years old. (c) Like all children, those afflicted with Down's Syndrome need emotional support and intellectual stimulation during their formative years. Children with Down's Syndrome are most responsive to love and affection; they are demonstrative and capable of giving their parents a great deal of love and satisfaction.

3) If the child is born out of wedlock or the parents express no interest in further involvement with the child, a suitable foster home placement may be possible.

4) Patients are accepted as guests to our institution for a short period when their presence in their own homes would be devastating to the family. This gives the parents a chance to work through their problems with whatever help we can offer away from the immediate stress caused by the presence of the afflicted child in the home.

5) We may advise a period of institutionalization for those children who have other congenital defects which are not immediately correctable and which make care unusually difficult for the parents. During this period the child will be evaluated by our consultants to determine the feasability of correcting the deformities so that the child may return home.

6) If the child should have an uncorrectable defect which is also incompatible with longevity, we will advise institutionalization if the parents are uneasy about caring for the child.

In spite of our attempts to support in any way we can those parents who are willing to try to maintain their mongoloid child at home, we still find it necessary to admit some young children with Down's Syndrome to the institution. We are now trying to impress on our ward personnel the importance of talking to the children and of using their own ingenuities and natural mothering instincts so as to encourage the early motor and mental development of our patients. Because of more intensive programming, our patients are developing at a better rate than did patients five or six years ago; but they are still not doing as well as their fellows who were fortunate enough to be reared in their own homes.

SUMMARY AND CONCLUSIONS

1) Twenty-five children with Down's Syndrome who are now ages 4-12 years and reared in their own homes by their parents, learned to walk and talk at a mean age of 4 years; they were toilet trained and able to feed themselves at 5 years. Twenty of them are now enrolled in special classes in public schools or day-care centers. Forty similar children who have been institutionalized since infancy learned to walk and feed themselves at a mean age of six years and talk and care for their own toilet needs at 8 years; only 10 of the 40 institutionalized children are able to talk effectively, presumably because of lack of speech stimulation. Statistical analyses indicate that the differences between these two groups are significant at the .01 level of confidence on all measures.

2) Twenty-five children with Down's Syndrome who were reared by their parents now have a mean IQ of 36 and SQ of 54; the 40 children institutionalized in infancy have a mean IQ of 18 and SQ of 29. Statistical analyses utilizing analysis of variance, indicates that these differences are significant at the .001 level of confidence.

3) Physical growth as indicated by height and weight at certain ages follows the third percentile until age 10 when it approaches the 10th percentile and then proceeds to the 25th percentile by age 12. Differences of physical growth between institutionalized and noninstitutionalized children are not statistically significant.

4) Physical stigmata of Down's Syndrome can occur in individuals with normal intelligence. In as much as early institutionalization may produce irrevocable damage to such individuals, chromosome studies are essential in order to substantiate the diagnosis before any long-term plans are made.

5) The young child with Down's Syndrome will not present unusual problems of care to his parents unless he has certain congenital defects. He will respond appropriately to love, training and intellectual stimulation. He will be ambulatory, verbal and independent in self care activities by the age of six years. There are school and day-care programs in most communities which will accept him.

6) The child with an incapacitating physical defect or a defect which is incompatible with longevity may be institutionalized. If the defect is corrected and the child regains his capacity of functioning, he should return to his own home.

7) Parents are more willing to raise their mongoloid child if they have the support, advice, and skill of their family physician to guide and encourage them.

8) Physicians and other professionals in institutions must set an example and thereby impress upon the minds of ward personnel, the importance of talking to the residents as the best way of stimulating speech development. Failure to do this allows the children to develop into beings who communicate only by grunts, crys, gibberish and gestures. Children in institutions should be encouraged to walk by themselves and care for their personal needs as soon as they are able to learn.

THE AUTHORS are grateful to members of the departments of medicine, social service, psychology and nursing at Plymouth State Home and Training School who have recorded a wealth of information about our patients; to Miss Judith Stack, M.T., A.S.C.P., James Alston, Noble Kheder, Mrs. Barbro Hicks and Ronald Wilson, B.F.A., P.P.A. and R.J. Giesige, Jr. for technical assistance; to Mrs. Barbara Gariepy of Wayne State University Computer Center; and to Miss Kathy Hoye who typed the manuscript.

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Editorial Note:

The problem of advising the family with a child with Down's Syndrome is a very difficult one. It is fraught with many perils including that of the physician's own emotional make-up. The author certainly gives us food for thought.

A STUDY OF ITS EFFECT ON 50 FAMILIES

Severe Asthma in Children

JAMES A. McLEAN, M.D.
JULES SCHRAGER, M.S.W.
VICTOR R. STOEFFLER, M.S.W.
ANN ARBOR

While many advances have been made in knowledge of the factors causing bronchial asthma as well as in the various allergic, pharmacologic and emotional treatment modalities available, there still remains a "hard core" of asthmatic children who experience severe, chronic, intractable asthma which is resistant to present forms of therapy.[1]

Considerable thought has been given to the reasons for this intractability in certain children's asthma. Various members of the health profession have shared a common concern regarding the treatment of these asthmatic children.

The allergist or pediatrician seeing the child in the office, clinic, home or hospital is frequently impressed with the resistance to treatment which characterize this patient population. Resistance in this sense is construed as any response to a therapeutic regime which does not yield satisfactory improvement, i.e., little or no amelioration of the asthma. Thus, a patient's lack of response to one or another antibiotic and pharmacologic regime (with or without steroid therapy), dietary schedule, hyposensitization, avoidance program and hospitalization constitute one pattern of resistance. Similarly, a parent's inability to carry out a prescribed program adequately constitutes another form of resistance.

Quite commonly it is observed that there appears to be an interdigitation of the forms of resistance. The psychological and emotional interactions between children and parents, the emotional climate in the home and community, and the degree of stress (e.g., separation experiences, periodic changes in environment, school failure, economic instability, etc.) all may conduce to the development of a situation within which the most effective medical management risks failure.

In order to begin to explore the dimensions of the problem and develop some guidelines for continuing work, an exploratory project was undertaken by members of the Allergy staff in collaboration with the Department of Social Work, University of Michigan Hospital. The charge given to the investigators was as follows: To interview and collect data on a sample of families whose family physician considered their child to have severe chronic asthma, the sample to be drawn from various areas of the state on referral by physicians in private practice. The specific objectives were twofold: (1) to further document the existence of a significant number of children with severe, chronic asthma; (2) to describe the impact of such an illness on the family constellation and its functioning.

Practicing allergists and pediatricians throughout the State of Michigan were initially contacted by letter informing them of our proposed investigation and inviting their participation, requesting (1) that they provide the names of families in their practice having an asthmatic child who, in their judgement, had severe asthma and was resistant to treatment under present circumstances or manageable only with chronic steroid administration and (2) inform the families of their (the doctor's) participation in this project and encouraging the families' cooperation. In this fashion, 23 physicians identified 62 such families, and the first 50 were interviewed.

Form letters were then sent to the families requesting their assistance in this project, referring to the family physician by name as the source by which they became known to us. Simultaneously, the referrals were organized by geographical distribution and contacts made by the Department

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Doctor McLean is professor of internal medicine at the University of Michigan Medical Center; Mr. Schrager is director of the department of social work, University Hospital, and assistant professor of the U-M School of Social Work; Mr. Stoeffler is assistant director, department of social work, University Hospital, and clinical assistant professor, department of psychiatry, U-M Medical Center. John M. Sheldon, M.D., now deceased, assisted in the early preparation of this paper while director of the U-M Medical Center Section of Allergy. The study was supported by a grant from the Michigan Tuberculosis and Respiratory Disease Association.

of Social Work with professional colleagues in social agencies and child guidance clinics in proximity to the family residence. In this manner a team of interviewers was recruited, all having appropriate professional preparation for undertaking this task.* A mimeographed questionnaire was developed by the Department of Social Work, University of Michigan Hospital, and the Allergy staff around which could be conducted a structured interview, and these, with full instructions regarding their use in obtaining additional material which appeared pertinent during the interview, were sent to all of the interviewers.

By telephone contact, each interviewer then introduced himself to the family, referring to the family physician and the University as his sponsor and requesting an appointment to conduct the interview. All interviews were carried out in the family residence, with both parents in attendance in the majority of cases and often with the children in and out of the setting.

Accompanying each questionnaire was a rating sheet to be completed by the interviewer concerning the effect of the child's asthma on the family. This consisted of six items: effect on family economy; effect on other siblings; effect on parents' ability to cope with the child and his illness; effect on the total household; effect on patient's schooling; and effect on patient's relationship with his peers. These were graded on four degrees of severity: no effect, some effect, severe and very severe.

Interviews and rating sheets were mailed to the University Hospital whereupon three additional raters (the senior authors), employing the same measures, independently rated each case. In making a decision, each rater reviewed the 15-page questionnaire in its entirety and then again for the specific factors listed above. An assessment was made in this context, and scores were then assigned to each item on the rating sheet: no effect equaled 0; some effect equaled 2; severe equaled 3; and very severe equaled 4.

DESCRIPTION OF THE SAMPLE STUDIED

The 50 children referred by physicians were divided into age groups: Group 1 (3-6 years), N=12; Group 2 (7-10 years), N=21; Group 3 (11-14 years), N=15; Group 4 (over 14 years), N=2. (Table I).

Thirty-one children in the sample were males, 19 were females. Thirty percent of the referred group were first children. (Table II).

TABLE I

AGE OF SAMPLE

AGE (Years)	TOTAL
3 - 6	12
7 - 10	21
11 - 14	15
over	2
	50

TABLE II

ORDINAL POSITION

Ordinal Position	TOTAL
1	15
2	13
3	10
4	7
5	2
6	0
over	3
	50

Viewed in terms of racial distribution, the group was representative of the population of the state as a whole — slightly less than 10 per cent of the sample being Negro. It should be pointed out, however, that this figure would vary widely in different sections of the state, since the Negro population is mainly concentrated in the larger urban centers.

Each referral was rated in terms of the social class position of the father. In assigning a social class position to each family, the indicators used were employment and education of the breadwinner. The basis for this choice is found in the work of Hollingshead and Redlich[2] & of Harrison, et. al.[3], in their work on social class and mental illness in children. Five social classes were identified: Class 1 (unskilled or unemployed), N=12; Class 2 (skilled labor), N=13; Class 3 (lower white collar), N=14; Class 4 (upper white collar), N=4; and Class 5 (professional or executive), N=7. (Table III).

Of the 50 children in the group, more than 60 per cent came from families with three or more children. (Table IV). Six of these families were single parent families, due either to divorce, separation, or death of one of the parents.

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* Although there was some predictable unevenness in the skill of the interviewers, all eight were professionally trained at the Master of Social Work level and all were members of the Academy of Certified Social Workers.

TABLE III
SOCIAL CLASS

Social Class *	TOTAL
1	12
2	13
3	14
4	4
5	7
	50

* See text for description

TABLE IV
NUMBER OF CHILDREN IN FAMILY

Number	TOTAL
1	6
2	12
3	9
4	8
5	8
6	3
over	4
	50

Thirty-five of the children came from families in which there was a clear-cut history of allergic disease, 20 of these families having bronchial asthma as the manifestation. (Table V). Sixteen of the asthmatic children had, or had had eczema, and eight of these children also experienced hay fever. In 24 of these children, food elimination diets were being carried out for present or suspected food sensitivity, and this was questioned in six additional children.

TABLE V
MEDICAL ASPECTS

Significant family history of allergy	35
Significant family history of asthma	20
Associated atopic eczema	16
Associated hay fever	8
Food allergy found or suspected	24
Infections appeared important	32
Steroid therapy ("Burst" or continuous)	25

TABLE VI
COURSE OF ASTHMA

ONSET	Birth - 13 years
Mean	2.8 years
Median	1.5 years
DURATION	1.5 - 16 years
Mean	6.1 years
Median	6 years
SEVERITY	
Moderate to severe	10 patients
Persistently severe from onset	15 patients
Severe to moderately sever (steroids)	19 patients
Variable severity	6 patients

Infection seemed to be a very important factor in triggering or perpetuating the asthma in 32 children, 18 of which seemed to have a "cold" or infection much of the time and had received multiple courses or continuous antibiotics. All of the children had received or were receiving some type of hyposensitization therapy.

The onset of asthma varied from birth to 13 years of age, the mean age of onset being 2.8 years and the median being 1.5 years. The duration of asthma ranged from one and one-half years to sixteen years, the mean being 6.1 years duration and the median being 6 years. (Table VI).

Although all the children in this study were considered to have severe chronic asthma by their family physician or pediatrician, different degrees of chronicity and severity were evident at the time of the visit by the research interviewer. All of the children were or had been severe chronic asthmatics. At least 19 of the children were experiencing only moderately severe asthma at the present time due either to steroid therapy or partially effective medical management. Twenty-five children were on either "burst" or continuous steroid therapy. Ten of the children had experienced only moderately severe asthma at the onset and then progressed to severe and chronic symptoms while 15 had been severely asthmatic from the beginning. The remaining six children were characterized by asthma of variable severity.

RESULTS
EFFECT ON FAMILY ECONOMY

Within the limits of this study, we have tried to evaluate the economic impact of severe asthma in a child upon the family organization. Table VII provides some evidence of this effect. In our sample, the costs of medications ranged from $3.00 per month to $166.00, with 19 families paying more than $31.00 per month.* This study indicates that the higher costs seem to be borne by persons who are in the higher income bracket ($8,000.00 plus).** (Figure I). Given the fact

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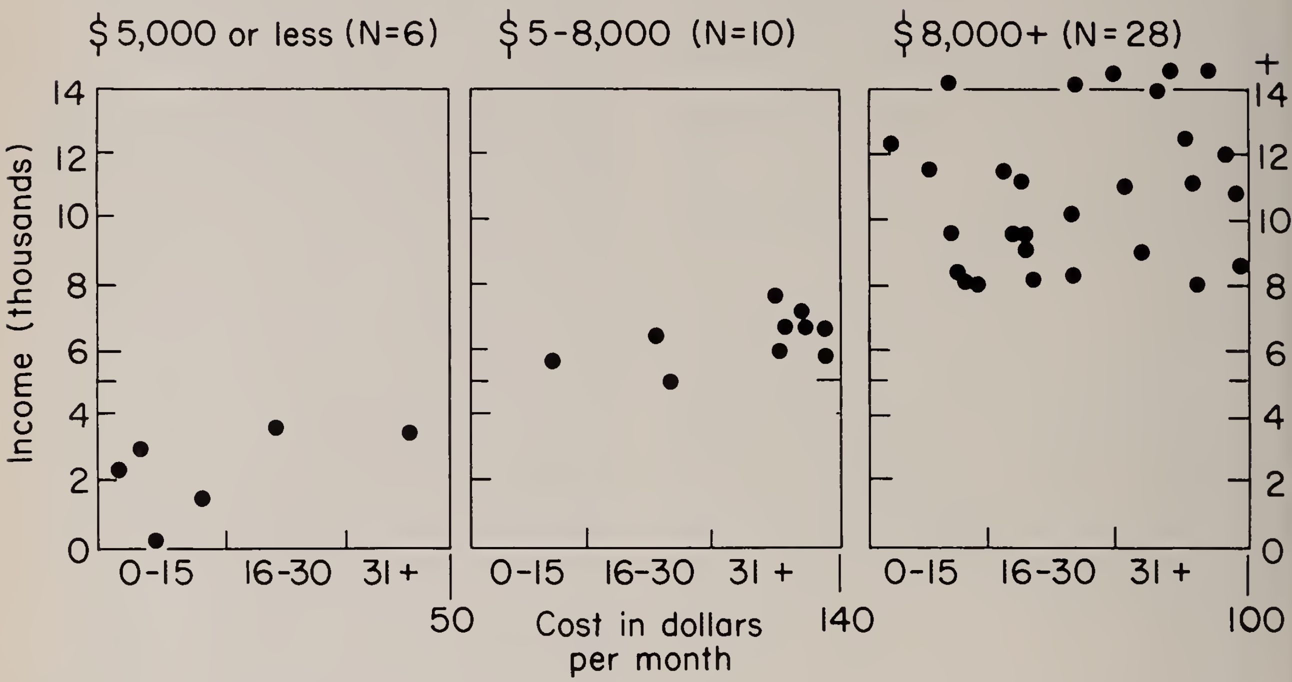
* The questionnaire used by the interviewers did not include a question regarding doctors' fees specifically but only the cost of medications; in some cases this included the cost of hyposensitization and epinephrine injections. Professional fees must be added to the amounts indicated above in order to arrive at the true picture of total medical management.

**Figure I contains 44 families whose income was stated. Table VII lists a total of 47 families whose medication expenses were known.

Figure I

EXPENDITURE FOR MEDICATIONS VS. FAMILY INCOME



that all children (with one exception) were seen by private physicians and all were referred on the basis of criteria which were applied equally, it is difficult to understand why higher costs were distributed in this fashion. Further analysis showed, however, that higher medication costs also could be related to the severity of the asthma. Reviewing the income ranges (as grouped in Figure I) vs. asthma severity, it can be seen from Table VIII that 50 per cent of the children from families with income of less than $5,000 per year were severe asthmatics, 70 per cent of the children in families with income from $5,000 - $8,000 were severe and 53 per cent of the children in families with income above $8,000 were severe asthmatics. Thus, it would appear that higher expenditures for medications by those families with a greater income may be partly but not entirely dependent on the severity of the asthma, but also related to income.

In 12 families both parents were employed. Significantly, of these 12 families, four earned less than $7,500 as the combined income of both parents, and their expenditure for medications for the asthmatic child ranged from $33 to $137 per month ($396 to $1,644 per year). Thus, unusually high expenditures struck that part of the sample least able to pay for service, and one could assume that the effect of this drain on the resources of these families must have had deleterious effects on the family as a whole.

TABLE VII

MEDICATION COST

$ 3 - $ 15 per month	13
$ 16 - $ 30 per month	14
$ 31 - $ 40 per month	6
$ 41 - $ 50 per month	4
$ 51 - $ 60 per month	1
$ 61 - $ 70 per month	2
$ 71 - $ 80 per month	1
$ 91 - $100 per month	4
$131 - $140 per month	1
$160 per month	1

TABLE VIII

ASTHMA SEVERITY VS. INCOME

Asthma Severity	Income less than $5000 per year	$5000-$8000	$8000+
Severe	3	7	15
Moderately Severe	3	3	13

One family paid a minimum of $25 a week for medical expenses and had gone bankrupt twice. Thirty-one of the families had purchased some type of special equipment for the home such as a dehumidifier, air filter, air conditioner or croup tent for the child's bedroom. Thirteen of the 31 had purchased two or more pieces of such special equipment. Most families, with the exception of five, did not suffer any significant economic hardship because of the hospitalization of the child. This was usually covered by insurance or by monies available through public sources. The stay in the hospital, although relatively short (generally under two weeks), simply represents a suppression of the acute crisis.

Although this study was based upon a small sample (and a rather selective one since all subjects but one were referred by private physicians), one can suggest that the evidence indicates that the effect of asthma in children upon the economic well-being of the family is appreciable.

EFFECT ON OTHER SIBLINGS

Review of the questionnaires revealed that children in some families resented the extra personal attention the asthmatic sibling required. This was found to be true in 16 of the 44 families with more than one child (36 per cent). There were 25 families in which this was not a problem and three families in which this was undetermined. The other siblings protested also the manipulative way in which the ill child demanded the attention of the parents or other members of the family. This was particularly true when the child was acutely ill and needed special care and attention from the parents, especially the mother. In three families siblings felt guilty about the asthmatic's condition in that they may have been "responsible" (through active play or some other kind of interaction) for the onset of an acute attack. It should be noted, however, that this information was not uniformly inquired about in the course of the interview but was offered spontaneously by the informants.

The parents of 17 families reported that their child-patient became irritable and crochety when suffering from the effects of an asthma attack. Whining, complaining, and aggressive behavior directed at others, including siblings, made them quite unpopular and to be avoided when symptomatic. The ensuing social isolation of the asthmatic child in turn may produce additional anger and guilt on the part of other members of the family social system.

EFFECT ON PARENTS

The child's asthma presented rather severe problems for some parents in essentially two ways: handling the physical and concrete realities of the disease; and handling the behavior of the child within this context. In 14 families at least one of the parents felt frustrated and bewildered. Twelve families reported work-time lost because of the child's asthma, and in four families this was a significant amount (1½ days a week in one family, "much work time lost" as contrasted to "little" in others). Thirty-seven families reported loss of sleep because of the child's asthma with one-half of these (18) reporting on the average of at least one hour per night lost. They realized that the care they gave to the ill child often took their attention from other members of the family who felt "short changed."

Parents become concerned about the child's activity at home and at school and how this may affect his health. Most parents would consciously wish that the child could run and play like other children but at the same time do not want the child to become overtired or involved in activities which might precipitate an asthmatic attack. They feel that the price they and the child might pay for taking undue risks is too great, and they would rather "play it safe."

Many parents (30 families) have a difficult time in coping with the child and his illness because they fear that their normal, spontaneous attempts at discipline might be contraindicated. Frequently this results in a "double standard" of discipline; one for the asthmatic child and another for the well child. They fear that punishment and restriction will upset the child and cause an attack of asthma; and so they refrain from employing their parental prerogatives. The parents feel frustrated because they feel that the child has manipulated them and guilty because they are not being consistent with other children in the family.

EFFECT ON TOTAL HOUSEHOLD

The existence of chronic asthma may have its disabling effects on the entire household because the disease and its consequences, rather than the needs of all the individual family members, may dictate the adjustment of the family unit in many areas of living and over an indefinite period of time. In half of these families activities were frequently curtailed or abandoned because the asthmatic child could not participate, and thus the whole family suffered from the restriction. For example, some families would not go where it might be dusty, or where a heavy pollen or dander exposure was likely. Wet, damp weather is often an inhibitor of activities whether they be routine, recreational or pertaining to school. Parents are unwilling to leave at home a child who is acutely ill and reluctant to hire a baby sitter to stay with the child for fear that a crisis might arise during their absence. Hence, many families are bound pretty close to home when they might ordinarily choose to do otherwise. For a few families, repeated hospitalization of the asthmatic child draws the parents (especially the mother) physically and psychologically from the home and the other siblings.

EFFECT ON PATIENT'S SCHOOLING

Eighteen children missed more than 20 days of school per year. Some children were good or excellent students, and being absent from school for repeated or extended periods of time did not seem to have an adverse effect on their academic performance unless of course those students who were described as "average" could have become "good" students if they had missed less school. Table IX shows that the majority of "poor" students actually missed less time than the "good" and "average" students. Other reports have shown that the intelligence of asthmatic children is representative of the general population. The number of students in the "good," "average" and "poor" performance categories in Table VIII is in accord with this observation. Twenty-five of the children had to restrict their school activities because of asthma. For example, they had to stay inside the school on damp or wet days when others could be outside. Gym and playground activities were not allowed or were limited.

TABLE IX

SCHOOL PERFORMANCE VS. SCHOOL ABSENCE

SCHOOL DAYS MISSED	TOTAL	STUDENT PERFORMANCE		
		"Good"	"Ave."	"Poor"
0 - 10 days	13	5	5	3
11 - 20 days	7	4	2	1
21 - 40 days	11	4	5	2
41 - 60 days	5	2	3	0
61 +	2	1	1	0
Unknown	3	0	1	2
Not applicable (Children not school age)	9			
TOTAL		16	17	8

EFFECT ON PATIENT'S RELATIONSHIP WITH PEERS

As a group, these children were not particularly undesirable as companions, nor did they have characteristics which were offensive to their peers. At least none was discernible from this study, except for irritability and complaining when having asthma.

DISCUSSION

It was observed that the child with severe asthma had varying effects on the family. Although many of the families found that the economic burden was very severe, the cost of hospitalization was lessened considerably by insurance programs for some of the families and public sources (Crippled Children's Commission and the State Department of Social Services) of support for others. It was observed, however, that 19 of the families paid more than $31 per month for medications. While higher income families paid more for medications, this cost did not necessarily reflect the severity of the asthma, since all income groups had children with severe asthma. Too, these families were better able to bear the cost of the medical regime recommended.

In the lower income groups, this financial burden certainly could have contributed to the "worry" over the chronic asthma. Regarding the 12 families with both parents employed, it is uncertain whether or not 24% is an unusually high figure for dual employment as contrasted to the total working population, but it would appear that the asthma cost could be a contributing factor to the necessity for dual employment in the families in this study.

While it has been shown previously that social classes 1 and 3 (as outlined above) are economically most vulnerable in our social system,[3] it should be noted that there were seven children with intractable asthma from professional and executive families in this study. While chronic asthma did not seem to have any relationship to social class, the economic effects were more profoundly felt by families from the lower socioeconomic groups.

Besides 36 per cent of the families with more than one child noting resentment by the other siblings over the extra attention given to the asthmatic child, problems in handling the behavior of the asthmatic child and his siblings were noted in 30 of the families (60 per cent). On the other hand the data indicate that the majority of families were apparently able to handle the asthmatic child and his brothers and sisters fairly adequately, and that these asthmatic children were able to keep up with the "average" school performance.

The impression is gained from reviewing the questionnaires that families felt considerable hardship at the time of onset of the asthma, and during the time when the asthma was being brought under partial control. When control was not achieved or was intermittent at best, stress was felt more continuously.

After a period of "reprieve" from acute symptoms and the need for intensive care, the family again felt the original strain at the onset of each exacerbation of asthma. Although the family may have been greatly inconvenienced when they lost sleep, had to pay a great deal for medicine and had to restrict the child from school and activities and even hospitalize him, after the symptoms subside they seemed able to return to a somewhat more normal routine. The continuation of subacute attacks, however, may have influenced the family's ability to adapt and manage the illness and the other children.

The total family may have experienced possible disruption in other ways. Feelings of uncertainty by the parents, both as to the medicines used in treatment and their own inability to help the sick child, reinforced the feeling of helplessness. Added to these factors are the resultant curtailment of the child's and family's activities and the problems of maintaining both love and discipline for all the children within the family.

The effects of these influences became unmanageable in some cases and become further complicated by the emergence of problems in siblings which might not have been precipitated if the total family situation were more "normal."

"Intractability" or "resistance" to treatment may be related at times to some of these factors. Programs for the management of such asthmatic children should take into account the total family. Therapeutic counseling for the family constellation has been recommended by others in the treatment of the institutionalized asthmatic child,[4] and our report has indicated that social factors appear relevant in many of these families of severely asthmatic children who were not institutionalized. On the positive side it should be noted that many of these families were apparently carrying on very well despite the potentially disrupting influence of the severely asthmatic child.

SUMMARY

The families of 50 children with severe, chronic asthma have been surveyed by social workers. The following parameters were specifically investigated: effect on family's economy; effect on other siblings; effect on parents' ability to cope with the child and his illness; effect on the total household; effect on patient's schooling; and effect on patient's relationship with his peers.

Thirty-three of the families had a cost of $15 per month for medication expenses with 19 families paying more than $31.00 per month. Thirty-six percent of the families with other children noted sibling resentment toward the asthmatic child. Fourteen of the families felt bewilderment and frustration due to the chronic illness, and 30 families experienced difficulty in coping with the asthmatic child. Family activities and school activities were influenced in half of the cases. In addition, work-time and sleep-time loss were documented. In some families among this selected group of chronic asthmatic children, a total treatment program would appear to necessitate social and psychological, as well as medical aid.

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The Treatment of a Psychiatric Emergency In a University Hospital Setting

ABSTRACT — One of the responsibilities of a University Hospital is the evaluation and appropriate management of psychiatric emergencies. A conceptual model of an "ideal" emergency program is presented, and a structural format for dealing with emergencies is outlined. The structure includes: a telephone service, a walk-in service, a crisis intervention clinic, a consultation service, and a flexible use of inpatient beds. The implications of the service-training-research triumvirate is discussed here in the context of the residency program.

BY PHILIP M. MARGOLIS, M.D.
JAMES M. ANDRE, M.D.
BOTH OF ANN ARBOR

INTRODUCTION

A 17-year-old boy was seen recently in the Emergency Room of a local hospital because he took an overdose of tranquilizers. A psychiatrist did not see him. He was given sedatives, and sent home with his brother who left him at the home of friends. It was suggested that he see a psychiatrist, though this information was communicated only to the boy.

Two days later, I received calls from the school nurse and the school principal who were concerned about his alternating violence and somnolence. He was brought into the University Hospital Emergency Room, was seen by a psychiatric resident who chose not to admit him. The Neurology resident was furious, but admitted the boy to the Neurology service. He was finally transferred to the psychiatric unit 24 hours later.

A University Medical Center has certain responsibilities — both to itself and to the extra-mural community of which it is a vital part. Many University Medical Centers are ambivalent about providing psychiatric emergency services, and departments of psychiatry are no exception. The decision — to provide or not to provide — rests upon many factors, not the least of which is the Department of Psychiatry's conception of its function. A University (General) Hospital is a logical focus for a community mental health center and should offer crisis-emergency services — a vital part of community mental health operations. A department of psychiatry must define, delineate, and assume the emergency responsibility for a community; the buck stops here!

OUR PAPER TODAY is not research. Rather, it precedes research — it lays a foundation upon which to build a concrete house for research.

Theoretically, the crisis school of psychology is gaining adherents. The theory posits that dealing with acute emotional crisis (a crisis = an upset in a steady state — Caplan), and with the acute phase of emotional illnesses often serves to deter or prevent chronic mental disease, at the same time building ego strength to better handle future psychic traumata. Preventive approaches, specific goal-directed (short-term) treatment, centering upon the current life situation, all are beginning to submit to and bear up under the wary eye of scientific scrutiny.

DEFINITION AND LITERATURE

An emergency can be defined in any number of ways. Anyone who phones, anyone who "walks in," anyone who is referred to the emergency service, could be automatically classified as an emergency patient. Shurley and Pokorney suggest that an emergency is always sudden and unexpected, always requires immediate attention to prevent serious damage. In essence, an emergency is defined by the urgency of the need to respond. This urgency can be felt by the patient himself, by his family, by the police, etc. Brothwood makes the crucial point that whatever the definition, the prompt assumption of clinical responsibility for the patient is expected and demanded.

In a national study of patients presenting themselves to the emergency room (6842 patients in eleven Emergency Centers), 27.3% were considered to have frank entirely psychiatric illnesses (and symptoms); another 25% manifested concurrent psychologic and "organic" — physical difficulties. Thus, at least half the patients presenting themselves for emergency care had either major or minor psychological distress.

ALTHOUGH DANGER TO self and/or others appears to be the most crucial criterion of a psychiatric emergency, we have somewhat arbitrarily divided the emergencies into six possible types: (1) suicidal — depressed; (2) homicidal — aggres-

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sional (overt violence is rare in the emergency room); (3) psychotic — reality breakdown; (4) panic — anxiety; (5) organic — confusion — delirium (e.g., drinking, drugs); and, (6) family and environmental intolerance.

As examples of the wide diversity of diagnostic categories which are (also) classified as psychiatric emergencies the suicidal, homicidal, and "excited" patients are compared. The suicidal patient may be depressed, schizophrenic, hysterical, sociopathic, or anxious. The homicidal patient may be paranoid, sociopathic, or schizophrenic. The "excited" patient may be acutely anxious or panicky, manic, catatonic, or hysterical. The "proper diagnosis" is, of course, secondary to an awareness and evaluation of the "emergency state," and the level of behavioral control is often its determinant.

"IDEAL" STRUCTURAL MODEL

Whether an emergency service is centralized, i.e., administrated and to some extent geographically represented under one aegis or whether it is "appropriately" distributed and as it were decentralized, is a moot point and depends on local issues, political and otherwise. Philosophically and technically, we favor a central locale, an integrated cohesive unit as close geographically and emotionally (attitudinally) to the medical-surgical-general emergency area as possible.

The ideal model contains five essential elements:

1. A 24-hour telephone service which should have a special Crisis-Emergency (CE) number, well publicized. This unit has five functions:
   (a) Suicide prevention.
   (b) Support, guidance, classification and advice.
   (c) Consulation.
   (d) Information.
   (e) Referral.

2. Walk-in Service (e.g., walking into the Emergency Room). Some walk-in centers are really trouble centers, handling both major and minor "disturbances"; many are store-front operations in the heart of a slum area — indigenous of the community; only a few such as Bellak's Trouble Shooting Clinic in New York City are attached to and a part of a general hospital.

3. A Crisis Intervention Clinic — four to six closely spaced outpatient interviews. A crisis team may make home visits.

4. Consultative Services.

5. "Back-up" Inpatient beds to be utilized on a flexible basis. Three units are envisioned:
   (a) For the patient to be held 4-6 hours.
   (b) For the patient to be held 24-72 hours.
   (c) For the patient to be held 1-4 weeks.

Implicit in these five elements is the concept of a collaborative-cooperative-liaison relationship with the agencies and institutions of the community. For example, collaboration assumes that an appropriate referral may be made with reasonable expectations that it will be successfully consumated.

The success or failure of an emergency service depends upon the flexible use of skilled personnel. The staff should be multidisciplinary, with both distinctive and overlapping skills, including a psychiatrist, a social worker, a nurse, a psychologist, a trained mental health worker, a secretary, and (perhaps) volunteers.

OUTPATIENT CLINIC — INNOVATION

Beginning July, 1967, the Psychiatric Outpatient Department of the University of Michigan Hospital undertook to improve service to the community, and at the same time broaden training experience for its residents, and to increase social research opportunities. The change involved a grouping and coordination under the direction of a senior staff psychiatrist, resident emergency psychiatrist, and a psychiatric social worker.

First, the team coordinated the emergency services of the Outpatient Department from 8:00 a.m. to 5:00 p.m. weekdays with identical services provided by the resident on call (ROC) evenings and weekends. An initial step was to establish brief meetings between the resident EP and the ROC twice daily. Here valuable information affecting proper services for the patient was communicated both ways.

Secondly, the resident EP manned the telephone. Incoming calls are received from patients, agencies, doctors, and relatives. Previously, entirely handled by the psychiatric social worker (who now serves primarily as a consultant on community resources), the resident takes calls requesting information, advice, and appointments for evaluation, reassurance, and possible admission. He attempts to assess the caller's needs and strengths, and makes appropriate plans for disposition. Often support, reassurance, and guidance lessen the urgency of the caller.

FOR TRAINING PURPOSES and for establishing links with the medical community, it is appropriate that the psychiatric resident take the initial telephone call.

Often communication is facilitated by a doctor-to-doctor contact. The mother of a patient hospitalized elsewhere came to the clinic requesting transfer of her daughter to our hospital. A brief interview enabled the resident EP to ascertain that the mother was reacting with strong feelings of being excluded because she had had no contact with her daughter's psychiatrist. Not only was she encouraged not to interrupt her daughter's therapy, but a call to the daughter's psychiatrist helped secure an interview for the mother.

The resident EP sees all walk-ins to the outpatient clinic and to the emergency room. The requests for help are similar in type to those received over the phone, but the presenting problem and need are more acute. Another area of service provided by the resident EP is emergency consultations to other services within the hospital. Though the immediate need is for management, there are opportunities to assist in making definitive, long-term plans to help the patient.

TIME, EXPERIENCE, AND improved communications are necessary to solve a number of problems. Almost immediately, we experienced difficulties with hospital administration policies which control setting of fees. This problem is especially poignant for the walk-in who needs to talk briefly with the resident EP. However, the policy directs that the walk-in register, pay a fee, and *then* see a doctor. Another problem is the need for short-term crisis intervention beds, perhaps two to four beds designated for such use by the resident EP. Within the general community problems also exist, e.g., the reluctance of some agencies and physicians to accept certain referrals.

PROBLEMS IN COLLABORATION and coordinating services among existing agencies must be worked out. An example is the similar, but separate and uncoordinated efforts of the various student mental health services within the university community. The student from out of state, living alone, having few friends, and in psychological, social and legal difficulties requires a solid community team effort.

Some recently collected data is used to illustrate the contacts made by the resident EP and the psychiatric social worker. In the first six-week period there were 223 contacts involving 182 cases. Of the 182 cases, 49 were seen personally and 133 handled over the phone. Without offering a complete breakdown of data, it is interesting to note the following: Of the 49 seen personally, the largest number were self-referred (1/3); 1/5 were referred by the emergency room.

If psychiatric staff were "stationed" in the emergency room, it is likely that more patients would be seen and appropriate disposition made right then and there. Additional advantages are obvious,

CO-AUTHORS

Doctor Margolis is professor of psychiatry, University of Michigan Medical School; Chief of Social and Community Psychiatry; Director of Washtenaw County Community Mental Health Center; Doctor Andre is a resident, Outpatient Department, University Hospital.

ANDRE

MARGOLIS

including improved communications and relations with the rest of the medical, university, and outside communities. The authors have had "emergency" calls from mental health professionals, patients, and relatives about the patient having been seen in the emergency room for "physical complaints," then having been sent home without their "psychological distress" having been checked out by a psychiatrist.

After the initial contact, 1/4 of the patients were able to accept a routine appointment, and another 1/4 were able to follow through a referral to another agency. In these instances, a short but definitive personal interview effectively screened the "emergency."

Of the 133 cases handled over the phone, the observations are similar. The largest number (2/5) were self-referrals; a significant number (over 1/4) were referred by physicians. Here the data suggest that after initial contact with the doctor, the caller was most often able to accept a routine appointment (over 1/2), or information and recommendations (1/3).

A limited "follow-up" study suggests that the emergency disposition made by the resident EP was successful. Of 92 patients given appointments over this period, only 12 failed to keep their appointments. Of 20 referrals made to other agencies, only 3 patients failed to carry through. Of 51 patients given information and recommendations, 49 considered the information helpful and followed the recommendations.

THE TROIKA

The functions of a University Medical Center are training, research, and service. These three need to be considered as an integrated package.

This new venture of the Outpatient Psychiatric Clinic provides an unparalleled training opportunity in community psychiatry for residents and (potentially) for many mental health disciplines. Andre contends that the duties of the resident EP can be viewed as an elaboration of the experience gained working with the "community" of inpatients. The same experiences of diagnosis, treatment, planning, organization, and decision-making as a team member are broadened and intensified. By mobilizing and coordinating forces, the resident learns that hospitalization can indeed be prevented.

A 53-year-old schizophrenic man, living alone, but hearing voices for the past four years came to the Outpatient Department. Previous contacts with two agencies resulted in identical recommendations — that he go voluntarily (or involuntarily) to a state hospital. By coordinating efforts of two agencies with his own efforts, the resident EP was able to provide medicine, outpatient therapy, and community support, and the man continues to work regularly and is improving.

THE RESIDENT DEVELOPS flexibility through shifting role functions, e.g., as therapist, consultant, and administrator. Training in decision-making and the exercise of authority with good judgment is given the resident EP through his experience and through his daily supervision by a member of the senior staff. There is ample exposure to enhance the *general* training of all residents, and, for some, it will stimulate interest in further subspecialization in community psychiatry.

Ideally, a psychiatric resident should be assigned to the emergency room during the day, then to be on immediate call after 5:00 p.m. He could be in his 2nd or 3rd training year, the rotation integrated into the regular three-year residency training program. Besides receiving training, he would teach the intern and several (Senior) medical students assigned to the emergency room.

The research potentials are enormous. Besides measuring what it is doing, a University Hospital Psychiatric Emergency Service could gather data re community needs, resources, and their utilization. Collection and interpretation of epidemiological data are fair game for a University Emergency Service serving the community. The origins and process of emerging (psychologic) illness, the role of crisis in ego development, and experimentation with new treatment techniques are only a few of the crucial issues to be examined. The mental health student (of whatever persuasion) should be involved in research effort as part of his basic training program.

By establishing closer and warmer relationships with the rest of the community, the University gains added community respect *and* self-respect. It, thereby, serves its students, faculty, and the people of the State well.

FINIS

By our own present definition of the treatment of a psychiatric emergency, the preliminary study done by Andre (as well as a more definitive study recently accomplished by Neal) suggest that we have been "successful" — people are getting *immediate* help.

Evidence is mounting that immediate help is real and that improvement in symptoms and functions is often maintained. Implicit in this paper is the hope that the ideal model described will be implemented and translated into a real model.

Adults tend to envy adolescents because adolescents have not *yet* wasted their opportunities. Let us not waste ours!

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Editorial Note:

This article should point out to those in charge of Emergency Room Service the need and possible solutions to psychiatric problems. It is also worth noting in this modern day when forces on all sides suggest "total involvement" that psychiatrists are taking a look at the overall medical picture and are suggesting their own involvement in the acute care of patients.

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Medicine and the Law

ABSTRACT — The divergencies in the philosophies and practical applications of medicine and law in their interrelation must be reconciled to obviate procedural and semantic differences in approach. The objectives, helping patient and client, are at one in motivation. Exchange education between the professions regarding the processes of each would be helpful. Practical aspects of the application of medicine and law are being sought through four major plans now operative. These are described and discussed.

BY MAX KARL NEWMAN, M.D.
DETROIT

PHILOSOPHIES OF LAW AND MEDICINE

The art of medicine and the philosophy of law must be intertwined, for 80 percent of all trial cases require medical proof.

Medicine has passed through three stages of development: diagnostic, preventive, and rehabilitative. Medicine's purposes are to maintain the patient in good health, to overcome disease and injury, and to lengthen his life span. Medicine evolves from the laboratory and clinical application by scientific process. Law's purposes have been peace and order and the pursuit of truth for justice, including the safeguarding of human rights and the concept of equality of opportunity. The two professions must serve the whole man. Their common goal is the pursuit of truth.

Justice Felix Frankfurter was rightly critical in saying: "Doctors and Lawyers follow their calling too narrowly; they live too exclusively within the professions; they do not cultivate enough intellectual detachment." The great need in both professions is not specialized practitioners but rather civilized practitioners to serve the common denominator — man.

People follow medicine; the law follows people. Patients accept new preventive, diagnostic, and therapeutic practices with reliance on and faith in their physicians. The community may refuse to accept new legal rules of conduct in the administration of justice; thus, new decisions for orderly progress of law may follow. Law undergirds its laws with the community mores, experiences, customs, and culture. This explains why people follow medicine but although they must be led by law, in the sense of the law's insuring stability, the law follows the demands of the culture of the people.

The philosophies showing the general relations between law and medicine have been classified as divisive factors by Mr. Oliver Schroeder, Professor of Law at Western Reserve University, Cleveland, Ohio. They are grouped under: (1) purposes, (2) relationship of patient and client, (3) semantics of medicine and law, (4) rate of advancement of law and medicine, (5) problem of how to bring the two professions together.

RELATION OF PATIENT TO PHYSICIAN OR CLIENT TO LAWYER

The physician serves the human being, primarily influenced by nature but always mindful of the health of the other members of the environment. The lawyer serves his client but the influence of the rights of other human beings must be preserved. The comparison shows more similarity of motive than differences of objective. Both professions serve the human being from a completely different approach, but both emphasize the integrity of the human being.

SEMANTICS IN MEDICINE AND LAW

A major divisive element between the physician and the lawyer is in semantics. This is because of the differences in emphasis, the separate professional terms of reference affecting meanings, and because of the differing responsibility of the professions to patient and client.

THE AUTHOR

Doctor Newman is associated with the department of physical medicine and rehabilitation, Detroit Memorial-South Macomb Hospitals.

Because medicine contributes to the administration of justice, it is necessary to understand the medical-legal terms. Such an understanding prevents the physician's conflict with the legal rules and statutes. Semantic reconcilement of terms of reference is mandatory. Terms have been appropriated to connote the application of medical knowledge to the administration of law and justice: "Forensic medicine," which originated in England; "legal medicine," which is of French origin; the "Gerichlichte Medezin" of the Germans, and "medical jurisprudence," an American term for the application of medical and surgical knowledge and skills to the principles and administration of law, comprising legal subjects having a medical aspect; thus, medical jurisprudence.

In general, it is necessary to have semantic understanding of medical-legal responsibility in relation to the four major groups involving the physician: (1) the medical organization, including State licensure, medical organization relations within medical societies, hospital management associated with staff functions and duties; (2) criminal law and its relation to forencis pathology and psychiatry and physiatry; (3) insurance in civil law in which the physician is most involved: personal injury (mostly in automobile accidents) and workmen's compensation and third party actions (usually associated with public building accidents) ; or malpractice in its many manifestations; (4) public health and industrial medicine, including pure food and drug activities, social security laws, and functioning of federal agencies under general tort laws.

Physicians consider that certain factors may produce illness even when the influence of those factors is only minimal. Those factors, whether etiologic, predisposing, or precipitating, must all be handled medically regardless of which is actually causative. Law requires only that 51 per cent probability of casual factors be present for legal responsibility. Hence a charge by a judge to a jury would be: "If you find the preponderance of evidence, which means the greater weight of evidence, that the plantiff's physical condition was caused by the accident, you should find for the plaintiff." When the same words and the same concepts have different meanings, they do tend to separate people and professions, causing discord. Dr. Keith Simpson, eminent physician and legal counsel expert in England, has indicated that one rarely hears the supporting tactics: "That is not what I mean; what I was asking you, Doctor, was . . . " Dr. Simpson cites the only exception to this in the expert's testimony: "If counsel deliberately misphrases a reply in order to mold evidence to his case, he must be corrected. He will accept the rebuff with a wry smile."

Regarding the judge in relation to hypotheses, one might ask how the judge can permit the attorney to put so-called facts, which are really assumptions, to a witness to clarify a situation: "Just assume, Doctor, that swallowing of 7 grains of sodium arsenite did not have an effect," and then, if not stopped, the counsel could continue his hoodwinking. One should refuse to entertain such opinions unless ordered to do so by the Judge.

RATE OF ADVANCEMENT OF MEDICINE AND LAW

Physicians and scientists are accustomed to rapid progress in resolved areas of endeavor. They have difficulty in understanding the slow progress of practical law. Although break-throughs in basic research have been historically slow, they are not so slow as they were before the last half century. When a breakthrough has been experimentally valid, clinical application is rapid. The lawyer cannot always appreciate the increasingly rapid change in scientific concepts; hence, in cross examination, he may fail to understand why a physician's conclusion may have changed drastically from year-to-year during a protracted case.

HOW CAN THE TWO PROFESSIONS BE BROUGHT TOGETHER?

The physician and the lawyer, medicine and the law, must be pivotally, not tangentially, oriented. This can be done. As a result of interaction between the American Medical Association and the American Bar Association, functioning has become reciprocally helpful at the levels of the State Medical Society, the County Medical Society, and hospital groups.

The physician must cross over to the side of the law by accepting the responsibility of being a medical witness in court who provides truthful facts and admissible opinions to aid in the administration of justice. The lawyer must cross to the medical side to aid in the preventive, diagnostic, and therapeutic tasks of medicine. This means that the lawyer and the physician must attempt to resolve legal conflicts speedily, in order to prevent iatrogenic complications, and to get the best medical recovery of the patient and the best legal disposition for the patient. In workmen's compensation accidents, a fixed disorder may be precipitated on a non-organic basis — an iatrogenic disease. The concept of participation must be furthered by: (1) education at schools of medicine and law to permit students to gain a thoroughly understanding concept of the processes at work on each side; (2) professional societies where intermingling and exchange of information may improve cooperation; (3) instruction and research through publications, as is now being done also in the state journals of medicine and law in order to insure the exchange of information between the professions.

PRACTICAL ASPECTS OF THE APPLICATION OF MEDICINE AND LAW: OPERATIVE PLANS

At times physicians have accused attorneys of promoting malpractice claims when an attorney attempted to secure expert advice in testimony in problems related to personal injury or malpractice. In turn, at times attorneys have accused physicians of a "conspiracy of silence." Judges on their part have retaliated in some areas with the concept of the *res ipsa loquitur* doctrine in order to permit the plaintiff's attorney to bring a case to trial. As personal injury suits increased and the need for expert medical testimony increased, physicians often have been averse to appearing in court. The physician is placed in an atmosphere entirely foreign to his training. He is accustomed to presenting his information according to accepted scientific procedures, basing his conclusions on observation of medical data studied. He is accustomed to the privilege of speculative interpretation from all points of view, all possible alternatives, without dogmatism. In the legal adversary system, the replies of the physician to a series of questions in court must be dogmatically in the affirmative or in the negative, unequivocally and without qualification — an unthinkable position to take in medical reporting. Thus an experienced trial attorney, if he chooses, is able to modify, to distort the actual medically factual account. If the medical expert uses the word **opinion,** counsel may suggest that the reply is **guesswork.** The medical **view** becomes to counsel by **conjecture;** medical use of **belief,** counsel may dismiss as **theory;** if the physician is **convinced,** the counsel calls it prejudice; a suggestion of **cooperation,** becomes at least a hint of **collusion.** What the expert considers **logical,** counsel may concede is **plausible,** or what seems medically **self-evident,** is disparaged as **glib.** An accepted **current view** in medicine is denigrated as present-day **theory.**

Both personal injury and malpractice may represent negligence to the legal mind. It should be a responsibility of the physician in furnishing the expert information to define and differentiate, and it should be the responsibility of the legal procedure to allow latitude for such clarification. This would obviate the concept of the so-called **impartial medical witness.**

Several plans are in operation to further understanding between physician and attorney. These are outlined under four media of consideration: (1) Medical Review Committee; (2) Joint Physician and Attorney Review Panel; (3) Expert Witness and Advisory Panel (California Plan); (4) American College of Legal Medicine.

1. The MEDICAL REVIEW COMMITTEE is the usual constituted type of organization made up of physicians in a local medical society. This committee reviews the case and recommends either for defense or settlement. When the recommendation is for defense, help is given to the physician to organize the defense.

2. The JOINT ATTORNEY-PHYSICIAN REVIEW PANEL is operatively mainly in Arizona and is known as the PIMA plan. The local Bar and Medical Societies have joined hands professionally. The panel is made up of nine physicians and nine lawyers; the defendant and his attorney, and the plantiff and his attorney participate. When a claim of negligence or malpractice is advanced, the chairman of the local joint group is notified, and he sets a date for a pre-trial hearing before the joint panel. The claimant may present his case, and may include hospital records; the defense may give his version; witnesses may be heard on both sides. The panel considers the evidence, and considers whether the evidence of serious injury arising out of malpractice is or is not substantial. If the answer is in the affirmative, an attempt is made toward an equitable claim adjustment; if this cannot be achieved, the medical soci-

ety produces the needed expert during trial. If the answer is in the negative, the plaintiff attorney is not to post or file a suit. The records of the panel are confidential and official records are not kept. This plan is also functioning in Idaho, New Mexico, New York, Nevada, Pennsylvania, and Virginia. It has been operative for 10 years.

In the functioning of this plan the potential of litigation is in the hands of the plantiff attorney and plaintiff as is evidenced by exposure of all records to the plantiff attorney at an early stage, which may give him an undue advantage. If the lawyer agrees not to represent the client, the client is still free to go to another attorney, utilizing the confidential material divulged at the panel hearing. In small communities, because the professional and social relations are close, the Joint Attorney-Physician Review Panel works well.

3. The EXPERT WITNESS AND ADVISORY PANEL is generally known as The California Plan. It is operative in a number of communities through the State of California. It also is being used in the State of Utah, where variations for using witnesses in malpractice cases are under community consideration.

In the California Plan, County Medical Societies furnish a panel of expert witnesses to the plantiff attorney. Precedents for this are in Los Angeles, San Diego, and San Francisco. The panel of physicians is drawn from the different specialties. The individual physician reviews all the records, examines the patient, and forwards a written report to the attorney. Should the attorney be dissatisfied with the method of the physician, he has the right to petition for another physician who then would be assigned to him. The responsibility of the physician is to testify if a case goes to court. This is obligatory. During the process of testifying, he must not make reference to the panel or to the combined Bar and Medical Societies' participation. The physician is paid a reasonable fee for consultation, examination, review of records, reports, and his function as an expert witness.

This plan has a divisive effect on the medical profession. Moreover, it does nothing for the defendant physician. Further, it fails to eliminate the nuisance suit.

4. PLAN OF AMERICAN COLLEGE OF LEGAL MEDICINE. All members of the American College of Legal Medicine are graduates of law schools as well as being practicing physicians.

PRINCIPLES:

A. Elevate standards of legal medicine and sponsor medical-legal research in order to reduce baseless suits.

B. Offer services as disinterested third parties to attorneys, in evaluating the malpractice problem

(1) Learn clinical facts and apply them to existing law.

(2) Neither to seek excuses for the physician nor to build a case for the patient.

(3) Show that there is no conspiracy of silence, a charge arising from a large number of baseless suits, so that a natural reluctance for physicians to testify resulted.

These principles reflect the uncivilized history of the resolution of complaints of malpractice.

PROCEDURE:

A. Assign case histories to members in rotation, each to examine material and send to appropriate medical experts and legal experts. Materials are sent to patient's attorney and to his physician.

(1) The committee gives an opinion regarding whether prosecution of the lawsuit will be successful. The presumption is that the average lawyer will not sue.

(2) Insurance companies will be likelier to settle dubious claims; hence, benefit the physician. Also, the insurance company would be advised to settle the claim when justified.

(3) If the claim is just, the opinion being unbiased, the physician is more inclined to insist on an out-of-court settlement.

B. Anonymity: Participants' names in the American College of Legal Medicine are not available. Names of parties to the suit are not available.

Medical-legal Dissection

Functioning in the fashion described, the American College of Medicine intends to remove baseless suits, on the one hand, and afford justice to the injured on the other hand. This concept tends to remove some of the existing threats to good medical care.

The American College of Legal Medicine Plan does not eliminate problems of "products liability." The newer legal concept is to include the physicians because some pharmaceutical companies may be using "stuffings" to escape liability. The plan does not eliminate malpractice suits in which medical experts are not needed, such as in assault and battery, breach of warranty, or consent and abandonment.

SUMMARY AND CONCLUSIONS

What works in one community may not work in another. Plans to further understanding between the professions and to eliminate nuisance lawsuits now operative are: The Medical Review Committee; The Joint Attorney-Physician Review Panel; The Expert Witness and Advisory Panel (The California Plan) ; The Plan of the American College of Legal Medicine. These plans are described and their limitations indicated.

Responsibilities of orientation through the press and films sometimes boomerang through misinterpretation. The client may insist on claims. The patient's feeling of having been wronged may have nothing to do with medical procedure, as in technically open areas, such as assault and battery, breach of warranty, criminal procedures against the physician, consent areas not requiring a medical expert.

Participation between the professions would be facilitated by education at professional schools regarding the processes of each profession, by intermingling of legal and medical societies for exchange of information, and by publishing in each other's journals.

Medicine must be looked to to provide medical truths and truthful opinions to settle or adjudicate legal conflicts. Law must cross over to the side of medicine to aid in the physician's preventive, diagnostic and therapeutic tasks. This can mean resolving legal conflicts speedily, thereby permitting the best medical recovery of the patient-client. Semantic reconcilement of disparate terms would reduce professional divisiveness. Medicine should have the legal privilege during testimony of scientific qualification of procedurally imposed dogmatic "yes or no" responses.

Editorial Note:

At the present time all physicians in Michigan are cognizant of the costs of Malpractice Insurance and the reason for such costs. We must find some solution to the problem of malpractice suits.

—John W. Moses, M.D., Scientific Editor

Non-Diabetic Glycosuria

(Note: This is one of a series of brief comments concerning problems seen in patients with Diabetes Mellitus. Members of the Clinical Society of the Michigan Diabetes Association will be supplying this material at frequent intervals. Readers of this Journal who care for diabetic patients will benefit by looking for these presentations of clinical importance and usefulness.)

BY WALTER ANDERSON, M.D.
DETROIT

We usually mean renal glycosuria when a patient has glycosuria with a normal blood sugar and a normal glucose tolerance test. Often the criteria also includes glycosuria in the fasting urine. This condition may be familial due to a defect in the renal tubular absorption of glucose. Some authors have reported, in long-term follow-up studies, that as high as 63% of patients with non-diabetic glycosuria may develop diabetes. Therefore, this group should be tested frequently for diabetes.

Acquired renal glycosuria may be seen in pregnancy; from 10 to 25% of such patients have been reported to have a non-diabetic glycosuria due to an increase in glomeruler filtration or a decrease in tubular reabsorption of glucose.

During the use of glucocorticoids, glycosuria may be found. Glycosuria also may be present in association with certain central nervous system disease, nephrosis, myocardial infarction, hyperthyroidism, disease of the liver and post-gastrectomy states. A glucose tolerance test is always necessary to rule out diabetes in these cases.

Other sugars, as fructose, galactose, lactose, pentose, and mannoheptulose may appear in the urine and give a positive test for sugar with one of the copper-reducing reactions (clinitest, Benedict's). Therefore, one of the glucose oxidase reactive tests (clinistix or tes-tape) should be used to specifically indicate the presence of glucose.

Too often a patient with a positive urine test will be advised to have only a fasting blood sugar. Frequently this will be normal and the patient assured he does not have diabetes. This is well illustrated by the following case:

A 59-YEAR-OLD WHITE male was found to have glycosuria and had a glucose tolerance test. He was told this was normal and he had renal glycosuria and not diabetes. During the following 25 years sugar was found in his urine on at least five occasions. He had five fasting blood sugars and was told that they were normal, always then being reassured that he had renal glycosuria.

These fasting blood sugars were 120, 128, 120 and 116 mg. per 100 ml. One 2-hour postprandial sugar was 157 mg. per 100 ml.

This patient was seen on November 12, 1967 with a typical history of claudication of right leg after walking one block. Physical examination showed a well-developed, well-nourished white male; height 6 ft., weight 190 pounds, stripped. Examination was essentially negative except for the lower extremities where both feet were cold to palpation; there was marked pallor of the right foot on elevation. Popliteal and dorsalis pedal pulses were absent bilaterally while the right posterior tibial pulse was absent and the left one diminished.

Oscillometer readings: Right ankle, zero; right calf ½ unit; left ankle, zero; left calf, 2 units.

The fasting blood sugar was 118 mg. per 100 ml. (true glucose). Urine was negative for sugar. A three-hour glucose tolerance test after a high carbohydrate diet for three days revealed:

	Blood*	Urine**
Fasting	122	Negative
½-hour	194	trace
1-hour	256	4-plus
2-hours	242	4-plus
3-hours	238	4-plus

*mg. per 100 ml.; **qualitative glucosuria

The blood urea nitrogen (BUN) was 12 mg. per 100 ml. and the cholesterol was 262 mg. per 100 ml.

This patient was put on a diabetic diet of: Protein 90 grams, Fat 70 grams, Carbohydrate 160 grams, totalling 1630 calories. 15 units of NPH and 15 units of regular insulin was given before breakfast each morning. On discharge a 2-hour postprandial blood sugar was 100 mg. per 100 ml.

DIABETES IS THE most common cause of glycosuria; therefore, any patient with glycosuria should have a glucose tolerance test. Even a 2-hour postprandial blood sugar may not be adequate, for in early diabetes this may be normal. A diagnosis of renal glycosuria should not be made unless it fulfills the diagnostic criteria of glycosuria in a fasting specimen with a normal blood sugar and a normal glucose tolerance test.

We must also remember that about 60% of the cases of glycosuria will eventually have a diabetic-type glucose tolerance test if followed over a number of years.

The Author, Doctor Anderson is an attending physician at Harper Hospital, Detroit.

VIEWPOINTS

Are You Participating, Too, In Search for Solutions?

BY JAMES B. BLODGETT, M.D.,
SPEAKER, MSMS HOUSE OF DELEGATES

The following comments might be the personal code for every physician — but how often are they?

> *"If I am not willing to participate in the search for the solutions to the problems of the times then I have relinquished this privilege to others who are willing to become involved.*
>
> *"If I am not pleased with their solutions to the problems I shall have no recourse nor any right to criticize."*

How often have you heard a physician voice those views rather than gripe and complain?

How often have you heard a physician make this kind of statement?

> *"If my children grow up and find this society an undesirable world in which to live they will ask me what did I do to protect it and to improve it for them and I must be able to answer, 'I did the very best I could.' "*
>
> *"I believe that we must be involved in the action and passion of our times or we shall run the risk of being judged not to have lived."*

The above comments were made at least by one Michigan physician . . . Jack M. Stack, M.D., of Alma. We refer to them here not only to pay tribute to Doctor Stack but to help set some high standards for all MSMS members.

These comments were offered humbly by Doctor Stack when he received the coveted Michigan Jaycee "Outstanding Young Man of the Year Award." Five such awards are given each year on a statewide basis and Doctor Stack is the only doctor of medicine so honored.

Doctor Stack, in receiving the award, pointed out:

> *"Many of our cynical friends question the validity of contributing a large segment of one's energies to community service, to partisan politics, and to professional organizational responsibility."*

As expected, Doctor Stack viewed the award as a new challenge:

> *"In my mind I shall consider this award to signify more than recognition of past accomplishments."*
>
> *"This award will parallel those other events in demanding of me increased participation, in offering new challenge and in exacting greater responsibility."*

On behalf of all MSMS members, I want to offer hearty congratulations to Doctor Stack who is serving now as president of his Gratiot, Isabella, Clare County Medical Society, as an alternate delegate to the MSMS House of Delegates, as vice president of the Alma Chamber of Commerce, as a member of the MDPAC Board of Directors and a finance chairman for the 10th Congressional District of the Michigan Republican Party.

Let's Boost MSMAS

BY G. E. MILLARD, M.D., CHAIRMAN,
MSMS ADVISORY COMMITTEE TO MSMAS

"Progress through Professionalism" will be the theme for the 1968 convention of the American Association of Medical Assistants with several Michigan ladies playing prominent roles.

More Michigan medical assistants will be able this year to make the short trip to the AAMA meeting in Columbus, Ohio October 9-12. All who attend the combination business-educational convention will benefit. Their physician-employers too will benefit as the medical assistants increase and improve their knowledge and insights.

The AAMA House of Delegates again will consider proposals for expanded programs. Michigan will be proud to have Betty Lou Wiley, of Port Huron, a past president of the Michigan State Society of Medical Assistants, preside as Speaker of the AAMA House of Delegates.

The AMA House of Delegates in San Francisco again praised the AAMA, noting that the group has grown to 12,000 members in less than 10 years. The AMA resolution, in part, urged every physician "to become fully acquainted with the objectives and programs of the AAMA, and to encourage his own assistants to seek membership in the national association and its local and state affiliates, and to participate in their education and certificate programs."

Physicians should stimulate membership and participation in the MSMAS and its local units in Michigan because the organization helps train the assistants and helps develop effective allies in many MSMS efforts in legislation, communications and medical education.

Many articles and photos about the MSMS House of Delegates and Annual Session will appear in the October News Extra and the November issue of Michigan Medicine.

See Page 1243 about "Outstanding Physician of the Year Award" to Marjorie Peebles Meyers, M.D., of Detroit.

MAGP Symposium On Immunization Set Oct. 6 at MSU

About 350 physicians are expected to attend the Symposium on Immunization sponsored by the Michigan Academy of General Practice Sunday, October 6, at the Kellogg Center in East Lansing.

After lunch Andrew D. Hunt, Jr., M.D., Dean of the Michigan State University College of Human Medicine, will speak on "How to Graduate More Family Physicians."

The program is acceptable for 6 prescribed hours by the American Academy of General Practice.

Physician's registration fee, including lunch, is $10.

MSMS-MHC to Sponsor Careers Workshop Oct. 23

Officials from many Michigan universities and health associations have accepted invitations to speak at the Health Manpower Conference, October 23 near Battle Creek.

The Michigan State Medical Society and the Michigan Health Council, joint conference sponsors, have invited representatives of county medical societies, hospital board members, hospital administrators, school counselors, community college officials, county supervisors, nurses and other interested in health manpower.

The program, which will run from 9 a.m. through dinner, will be held at the Michigan Education Association Conference Center on St. Mary's Lake.

Robert E. Rice, M.D., Greenville, Chairman of MSMS Committee on Rural Medical Service, will preside as chairman.

Copies of the complete program are available by writing MSMS, 120 W. Saginaw, E. Lansing 48823.

Among the many speakers will be Milford O. Rouse, M.D., Texas, past president of the AMA; Lionel F. Swan, M.D., Detroit, president of the National Medical Foundation; Charles Skinner, Jackson, president-elect, Michigan Hospital Association.

Also, William H. Knisely, Ph.D., East Lansing, member, National Advisory Council on Education for Health Professions; Robert Kinsinger Ed.D., program director, W. K. Kellogg Foundation. MSMS and MHC officials will participate.

Smoking-Health Speakers Set For Oct. 20

Topics ranging from smoking-related diseases to steps that may help smokers break the habit will be covered at the Physicians' Symposium on Smoking and Related Diseases Sunday, October 20, at MSU's Kellogg Center in East Lansing.

The session, designed especially for general practitioners, will include discussions of Vascular Diseases, Respiratory Diseases, Cancer of the Lung and Smoking Cessation Methods.

It will open with a welcome address by Lee Feldkamp, M.D., president of the Michigan Academy of General Practice, and remarks by George Pickett, M.D., deputy director of the Wayne County Health Department and former assistant director of the National Clearinghouse on Smoking and Health.

Speakers at the morning session are Vernon Wendt, M.D., of Grand Rapids, who will discuss "Cardiac Complications," and E. Osborn Coates, Jr., M.D., of Detroit, speaking on "Respiratory Diseases."

An afternoon session on lung cancer will include: "X-ray Diagnosis of Lung Cancer," Charles O. Long, M.D., Lansing; "Clinical and Surgical Evaluation," Cameron Haight, M.D., Ann Arbor; and "Pathology of Lung Cancer," R. Abell Murray, M.D., Ph.D., Ann Arbor.

Alfred Soffer, M.D., editor-in-chief of *Diseases of the Chest* will discuss "National Approaches to Smoking Cessation and What the Office Practitioner Can Do," and Arthur Weaver, M.D., Detroit, will outline methods of smoking cessation.

Roundtable discussions will follow both the morning and afternoon programs.

Sponsors of the symposium include Michigan Academy of General Practice, Michigan Council on Smoking and Health, Michigan Health Council and MSU's College of Human Medicine, and other health-related organizations.

Battle Creek Clinic Day Program Set

A Western Reserve University surgeon will describe medical problems that exist in remote sections of Australia and New Guinea when he delivers the feature lecture at the annual Southwestern Michigan Clinic Day Thursday, November 7, in Battle Creek.

Brown M. Dobyns, M.D., professor of surgery at Western Reserve, will deliver the annual Russell L. Mustard Memorial Lecture to conclude the day-long event at the Battle Creek Country Club.

The lecture is sponsored by the Calhoun County Medical Society.

The Clinic Day, which begins at 9 a.m., will be devoted to a Symposium on Cancer Therapy, sponsored by Lederle Laboratories.

Speakers and their topics include: Edward G. Krementz, M.D., of New Orleans, "Advances in the Diagnosis and Treatment of Melanoma;" David M. Sklaroff, M.D., of Philadelphia, "Recent Advances in Radiation Therapy;" Richard A. Oberfeld, M.D., of Boston, "Prolonged Intra-arterial Infusion Cancer Chemotherapy for Advanced Cancer;" and Charlotte T. C. Tan, M.D., of New York City, "Solid Tumors in Children."

Following the lectures will be round table discussions involving the four speakers, with ample time for questions and comments, according to Robert W. Brown, M.D., chairman of the Clinic Day committee. Also scheduled is a noon luncheon.

Interested MSMS members in Southwestern Michigan are invited. Programs are available from Robert W. Brown, M.D., 231 North Avenue, Battle Creek 49017.

HEW Issues New Report on RMPs

The following box-score has just been released by the U.S. Department of Health, Education and Welfare to give the current status of the Regional Medical Programs to implement the federal heart-stroke-cancer legislation:

Twenty-three Regions are now operational. They include the 10 most recently funded operational Programs which are . . .

California
Central New York
Georgia
Iowa
Maine
Memphis
Michigan
New Mexico
South Carolina
Texas

One new planning grant has been awarded to the Puerto Rico Regional Medical Program.

Applications from a total of 11 Programs to become operational are in the review process.

Continuing and supplemental planning and operational grants have been made and others are under review.

Bronson Clinic Coming Oct. 16

Physicians in Southwestern Michigan are invited to attend a conference devoted to "Current Concepts of Renal Disease" Wednesday, October 16, in Kalamazoo.

It will be the ninth annual Clinical Conference at Bronson Methodist Hospital. Registration is at 8 a.m.

Speakers will include John P. Merrill, M.D., of Boston; Charles V. Pryles, M.D., of Brooklyn; Thomas F. Meaney, M.D., Cleveland; and Conrad L. Pirani, M.D., Chicago.

MSU Adds Research Scientist from NIAID

Norman B. McCullough, M.D., research scientist with the National Institute of Allergy and Infectious Diseases, recently joined the MSU College of Human Medicine as professor of microbiology and public health and professor of medicine.

Doctor McCullough, who spent the past 10 years as chief of the Laboratory of Bacterial Diseases, is known internationally for his studies in Brucella.

Manpower Act Signed, Extends Only Two Years

Physicians related to the three Michigan Medical Schools are especially interested in the details of several bills signed into law by the President.

President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the federal programs of aid to medical and allied health schools.

President Johnson termed the health manpower law "a major measure in the battle for better health." It authorizes about $1.2 billion in federal aid to medical and other health personnel schools over two years for construction, expansion and operating expenses. Congress followed most of the Administration's proposals in approving the legislation but limited the extension to two years, instead of the four years requested.

Schools of pharmacy and veterinary medicine were made eligible for the first time.

Money authorizations for schools in the new law includes:

Medical and other health professions — construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

Southwestern Michigan Study Indicates Need for 25 Per Cent More Doctors

Michigan should have 25 per cent more doctors just to meet present needs, a study by the Michigan Health Council indicates.

Preliminary results of a medical manpower study in 14 Southwestern Michigan counties show the counties a need of an additional 268 physicians if they are to meet current demands for medical services.

"The need for nearly 25 per cent more medical doctors comes as no surprise to the Michigan Health Council," comments John A. Doherty, MHC executive director.

"Nearly every day we receive calls from doctors and other health leaders asking for help in obtaining additional doctors for their communities. Some doctors are becoming desperate about their situations. Some medical doctors with many years of specialized training in surgery and other medical specialties are having to go back to general practice because of the acute shortage of family physicians."

Physicians and hospital administrators who took part in the study estimated a need for 89 additional general practitioners and 179 medical specialists. They reported opportunities for 36 trained in internal medicine, 25 pediatricians, 22 psychiatrists, 18 obstetrician-gynecologists, and 11 general surgeons.

There are currently 1,122 paysicians within the 14-county area, 410 general practitioners and 712 specialists, serving a population of approximately 1.32 million, reports Mr. Doherty.

More than 95 per cent of the doctors interviewed believe the shortage of physicians would be helped immeasurably by expanding the two-year College of Human Medicine at Michigan State University to a full four-year, degree-granting institution. They also felt that medical schools at Wayne State University and the University of Michigan should be expanded.

Students currently enrolled in medical schools should be encouraged to pursue careers in family or clinical medicine, the survey participants said.

If the Southwestern Michigan survey requests, Mr. Doherty said, are projected for all of Michigan, the state would need upwards of 2,500 more practicing physicians. This alarming figure is much worse than a 1966 estimate by the Michigan Health Council which predicted the state was some 600 doctors short of meeting present medical needs of its citizens. An expanding population will probably make the future patient-to-doctor ratio even worse than the present 820-to-1, Doherty predicts.

The study was conducted with a grant from the Michigan Foundation for Medical and Health Education in the counties of Allegan, Barry, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Ingham, Jackson, Kalamazoo, Lenawee, St. Joseph and Van Buren.

Two Bond Issues On Fall Ballot For Recreation

BY ELMER WHITE
EXECUTIVE DIRECTOR
MICHIGAN PRESS ASSOC.

Michigan voters on November 5 will be asked to support the "Michigan Quality Recreation Proposal."

There will be two proposals, not dependent upon each other. One will be a $100 million recreation proposal and the other a $335 million water pollution control proposal. If authorized by voters, the state will bond itself for the $435 million.

PROPONENTS STRESS that the bonds can be sold with no increase in taxes. Retirement of other bond issues and economic growth will provide enough revenue to cover principal and interest payments within the present tax structure.

The $30 million earmarked for local recreation facilities would be available to communities on a matching basis with the state paying 75 percent of costs. The remaining $70 million would be spent for state parks, fishing areas, fish hatcheries, forest campgrounds, hunting areas, hiking trails, snowmobile trails, etc. Combined with local and federal funds, and estimated $170 million will be available for recreational purposes.

CLEAN-WATER PROPOSAL, if approved by voters, will help finance new sewage treatment plants, improvements to existing plants, and loans for new sewers. Some 150 communities are currently in violation of Michigan's pollution control law. These communities would qualify for 50 percent assistance from the state and 25 percent from the federal government in instituting a pollution control program.

About $50 million would be earmarked for sewer construction and $285 million for treatment plant construction and improvement. The addition of federal and local funds would provide more than $600 million to clean up Michigan's lakes and streams.

Now Is the Time For All Good Men

BY VERNON V. BASS, M.D.
CHAIRMAN, MDPAC

All of us know that government is deeply involved in planning, producing, and financing health care.

Approximately 2,000 bills of interest to medicine were introduced in the U.S. Congress this year, as were over 150 health bills in the Michigan Legislature.

The responsibility for endorsing, financing and helping to elect wise, dependable political candidates who will listen to the views of the medical profession before voting, rests primarily upon MDPAC and AMPAC.

Your state MDPAC committee has carefully assessed the voting records of all legislators and by election day, November 5, will have supported over 50 candidates for the Legislature as well as several key Congressmen. There are several candidate support committees of doctors and their wives actively helping in vital congressional races.

MDPAC can only succeed in doing an effective job of campaigning in ratio to the amount of financial help it receives from doctors of medicine.

May I urge each of you to assume your political responsibility first by becoming a contributing member of MDPAC-AMPAC and secondly by your political participation to help us select, elect and retain the best men we can get in office both in Lansing and Washington!

If you are not already a member, please join today.

Doctors Permitted To Subscribe Only For Blue Cross

Michigan Blue Cross-Blue Shield has sent the following memo to physicians in the Blue coverage group:

Since the recent implementation of the Blue Shield MVF-2 program in the Michigan State Medical Society some doctors have requested that they be permitted to retain only their Blue Cross coverage and not purchase the Blue Shield program.

Those of you who choose to carry Blue Cross only may do so. Appropriate refund back to August 1, 1968, will be made.

The Blue Cross plans available are:

1. Comprehensive hospital, which provides 365 days of care with optional "special dependents" coverage (Riders S & F).
2. Deductible hospital coverage ($50 per adult member per hospital bed-patient admission) with 365 days of care with "special dependents" coverage (Riders S & F).
3. Those members 65 and older may elect Blue Cross "65" complementary coverage which is designed to fill the gaps in Medicare.

Members of the Society desirous of exercising the above options should make their request promptly and in writing to: Central Correspondence Department — Mail Code 60, Michigan Blue Cross and Blue Shield, 441 East Jefferson Avenue, Detroit, Michigan 48226.

Wide Variety Of Topics Set For AMA Meet

Scientific sessions of wide medical interest are planned for morning and afternoon Monday through Wednesday, December 2-4 at the 22nd AMA Clinical Convention in Miami Beach, Fla.

Topics December 2 include the anemias, thrombophlebitis, obstetrics, white cell disorders and diseases of the lymph nodes, management of claudication, cerebral ischemia due to neck vessel occlusion, and gynecology.

Subjects for December 3, are cardiology, gastrointestinal diseases, proctology, and — in the afternoon — new approaches in cardiology, bacterial skin infections, and the skin and sunlight.

Discussions on sex will be held December 4, to include such topics as marital problems, changing sex values, preadolescent and adolescent sex education, and sex and the senior citizen. Other topics December 4 will be hypertension, kidney, pulmonary diseases, and respiratory ills in children.

Scientific sessions will be held in Miami Beach Convention Hall. Total registration is expected to be about 10,000.

OFFER MICHIGAN REHAB DIRECTORY; WRITE TO MSMS

A directory listing the state's rehabilitation facilities and services for physically impaired persons is available to physicians in Michigan.

The "Directory of Michigan Medical Facilities for the Physically Impaired" was published by the MSMS Committee on Rehabilitation.

Interested MSMS members may obtain a copy by writing the MSMS, 120 W. Saginaw, East Lansing 48823.

Marjorie Peebles Meyers, M.D., Honored As "Outstanding Physician of the Year"

Marjorie H. Peebles Meyers, M.D., Detroit, presented her report to the MSMS House of Delegates, Sunday night, September 22 as chairman of the "Committee to Select MSMS Members for Certificates of Commendation."

The next report caught Doctor Meyers by surprise!

James B. Blodgett, M.D., Speaker of the House, called upon D. Bonta Hiscoe, M.D., Lansing, chairman of the "Committee to Select Michigan's Outstanding Physician of the Year."

Doctor Hiscoe reported that the Committee was recommending an outstanding practitioner, educator, medical statesman and civic leader — Marjorie Peebles Meyers, M.D.!

The Delegates adopted the report unanimously and the award was formally presented to Doctor Meyers at the Delegates Dinner, September 24.

* * *

DOCTOR MEYERS, ACCORDING to Doctor Hiscoe in his Committee report, was selected for many reasons:

— Doctor Meyers is a highly-respected Detroit internist,

— Doctor Meyers is regarded as an excellent Assistant Professor in the WSU Medical School,

— Doctor Meyers is an active member of the Wayne County Medical Society and MSMS,

— Doctor Meyers is one of the MSMS alternate delegates to the AMA House of Delegates,

— Doctor Meyers is a hard-working officer and member of several Michigan and Detroit health, welfare, educational, and cultural organizations,

— Doctor Meyers was selected recently as one of the "Top Ten Detroit Women Who Work,"

— Doctor Meyers, who is married to a minister, holds a responsible lay position in the Episcopal Church in Michigan.

DOCTOR MEYERS DECIDED TO become a physician at age 13. There was nothing traumatic about the decision. "It was a hot, summer's night," she recalls, "and my parents had invited guests over for the evening. One of them asked me what I wanted to be when I grew up and I replied, 'A doctor.'" Fifteen years later she received her medical degree from Wayne State University.

Her childhood was warm, secure and somewhat sheltered. She was an only-child and grew up in Harlem before it became "what it is now." Her father, a special clerk on foreign mail for the Post Office Department, made sure his daughter developed an early interest in education. "I remember his coming home from work, turning the radio on softly and reading to me from the *New York Times*," she said. "It wasn't long before he had me reading the newspaper to him. I learned Shakespeare before I could write."

Not only was young Marjorie exposed to the world of books, she was taught a philosophy of life. "I had no problem with identity or any fear that there would be things I couldn't do. I was taught that a person can do anything provided he has it on the ball."

Although she was aware she was Negro, her environment cushioned her from most discrimination. The neighborhood was integrated and closely allied. People were friendly and took an active interest in the neighborhood youngsters.

Even when she entered Hunter College in New York, her close circle of friends buffered Marjorie from the racism of the outside world. "We were a motley crew," Doctor Meyers says of her schoolmates. "There were six of us who had gone through high school together and enrolled at Hunter. One was French, two were Irish, one was a German and one a Jew. I'm Episcopalian. We

The delegates applauded long and voiced enthusiastic approval for the selection of Doctor Meyers as the "Physician of the Year."

Doctor Meyers expresses her grateful thanks to the House of Delegates for the high honor.

stuck pretty close together. One day an English teacher asked one of the girls, 'Is Marjorie a Negro?' My girl friend replied, 'Gee, I don't know!' "

The light-skinned young lady suspected discrimination when she applied to Columbia Medical School in 1939. She had just completed her Master's program at Columbia. She was told that enrollment in the fall class "was impossible," enrollment the following year, "might be," but that enrollment three years hence, "was assured." She felt Columbia didn't really want her — not because she was **Negro** but because she was a **woman.**

DOCTOR MEYERS MARRIED the Rev. Frederick R. Meyers in 1939. He was a vicar in a New York church and the couple met through church work. Shortly after they were married, the Reverend Meyers accepted a call at St. Mathews in Detroit. His wife promptly made application to WSU Medical School. Reverend Meyers now serves as a Canon for the Cathedral Church of St. Paul in Detroit.

It was after admittance to WSU that Doctor Meyers felt the bite of discrimination.

"There were five or six women in our class. One day I noticed, through the mail box windows, white envelopes for all the girls except me. They looked like invitations.

"Without thinking I asked, 'What are all those white things you girls are getting?' The girl I asked looked uneasy, then drew me aside. She had tears in her eyes and told me they were invitations to pledge a sorority, and said, 'Oh Margie, you've been blackballed!' "

"I felt rather uncomfortable at the moment, but it was later that the reaction set in. I became so upset I flunked an exam. The more I thought about it the worse I felt, especially since a medical sorority is supposed to be composed of the cream of the crop. I finally became utterly and extremely ill. I didn't even mention it to my husband for days."

* * *

SHE RECEIVED her WSU medical degree in 1943, and served her internship and residency at Receiving Hospital, Detroit. The late Gordon B. Myers, M.D., former Chief of Medicine at WSU, influenced the young doctor's decision to specialize in internal medicine and serve her internship at Receiving.

Doctor Meyers believes strongly in a one-to-one doctor-patient relationship. "One reason I didn't specialize in Pediatrics is because you have a one-to-three relationship;" she says, "the child and his two parents. I like children, but I'm scared to death of sick children. That's another reason," she quipped.

She and her colleague, Eugene M. Shafarman, M.D., share facilities on the 11th floor of the Professional Plaza in the Detroit Medical Center, a half-block from Harper Hospital.

WITH A SLIGHT TRACE of Eastern accent remaining, Doctor Meyers is outspoken in her concern for a better public relations program for the medical profession, and especially for the American Medical Association. She points out that the profession is undergoing many changes, making many advancements, but that the public is usually not informed or ill-informed. "We never seem willing to admit that we can be wrong or make a mistake," she says. As a result, the public becomes suspicious of many things which are accomplished.

Critical of AMA, Doctor Meyers feels the organization still harbors racial prejudice. "The Na-

Doctor Meyers receives warm congratulations of Brock E. Brush, M.D., chairman of MSMS public relations committee.

tional Medical Association was organized because of the bias in the AMA towards Negro physicians," she charges. "And at the recent meeting in Houston, the AMA didn't even have the courtesy to send a representative.

"I'm a dues-paying member of the American Medical Association because I feel a person should not criticize something unless he also works to change conditions. I guess I'm doing both. And you can quote me on that," she added.

Doctor Meyers believes racial conditions are improving. "As recently as 18 years ago," she says, "there were certain beds designated at some hospitals for Negro patients. Negroes had to wait until a Negro bed was available before they would be admitted. This is no longer the case."

SHE ALSO BELIEVES that there is a severe shortage of Negro physicians, and that neither Negroes nor women are handicapped when pursuing a medical career.

"My advice to anyone who wants to become a doctor is always the same. If the person is a woman I ask, 'Do you plan to use your medical degree?' Women who plan to marry and raise families instead of practicing medicine should not try to become doctors. It's too expensive for both the student and the public which shares the cost.

"If the woman is going into medicine to work with people, she must be reasonably 'solid.' She can't be sensitive and think that people will do things for her simply because she is a woman. One's physical and emotional strength must be rated. But one of the most important requisites is a sense of humor. You must be able to laugh, especially at yourself.

"Finally, you don't look at the color of your skin if you want to be a physician. You look at what you have between your ears . . . and where you can get financing."

* * *

DOCTOR MEYERS IS a dedicated member and leader in many organizations. In addition to the groups named early in this article, Doctor Meyers is vice president of the Michigan United Fund, vice-president of the Detroit Urban League; active in the Neighborhood Service Organization which works with Detroit youngsters; treasurer of Detroit Adventure, a cultural group; a member of the Michigan Society for Mental Health; a board member of Boy's Republic; President-Elect of the Michigan Diabetes Association; a board member of the Michigan Heart Association; a board member of the Rehabilitation Institute; the first and only woman member of the Standing Committee for Advice and Counsel to the Bishop of the Diocese of Michigan of the Episcopal Church, a member of the Detroit Committee on Alcoholism, and a long-time worker for the Detroit YWCA program.

Horizons Unlimited

MSMS members may obtain copies of the AMA "Horizons Unlimited" career handbook with an eight-page Michigan insert by writing to MSMS, P.O. Box 152, East Lansing 48823.

U. S. POLIO CASES DROP OFF 99.9 PER CENT

Polio cases throughout the United States were down to 15 during the first seven months of 1967, virtually a 100 per cent drop in incidence since Salk vaccine was first used in 1955.

This represents the lowest national total on record, with only 10 states involved so far.

The Health Insurance Institute, citing United States Public Health Service reports, said 13 of the victims had contracted paralytic polio.

The peak year for the often-crippling disease was 1952, when 57,879 cases were reported. Since then, the Salk vaccine, and the Sabin vaccine, introduced in 1961, have all but eliminated the polio threat in this country. In 1955, 28,985 cases were reported.

AMA-NEA PARTNERSHIP

School health has been a particularly vital concern to the AMA since 1882, when it urged that hygiene be taught in schools. For 56 years the AMA has worked directly with the National Education Association to shape policies and practices in school health education and services.

COMING EVENTS

U-M Reunion Offers MSU Game, Oct. 11-12

One of the special highlights of the annual Medical Center Alumni Society Reunion at Ann Arbor October 11-12 will be the opportunity to cheer for the Wolverines on Saturday, October 12 against the rival Michigan State Spartans.

The two days of activities always include the football game, and 1968 offers the outstanding grid battle.

Special guests will be the 50-year graduates from the 1918 medical and nursing classes. Other alumni especially invited are those whose graduating year ends with a 3 or 8, such as 1923, 1928, 1933, etc.

Speakers will include Robben Fleming, U-M president; Dean of Medicine William N. Hubbard, Jr., M.D., and Dean of Nursing Rhoda R. Russell, R.N.

President of the Medical Center Alumni Society is John O. Goodsell, M.D., Saginaw. ☐

MSMS, U-M PLAN SEMINAR DEC. 1 ON ADOLESCENTS

MSMS, through its Postgraduate Medical Education Committee, will co-sponsor with the University of Michigan Department of Postgraduate Medicine, the 1968 Winter Symposium on "Creativity, Conformity and Concepts of the 20th Century Adolescent," at the Sheraton Ann Arbor Motor Inn, Sunday, December 1. The Symposium will be financed by Geigy Pharmaceuticals, a Division of Geigy Chemical Corporation. Copies of the program may be obtained from the Department of Postgraduate Medicine at the U-M Medical Center.

MEDISCENE

Oct. 9 — Family Life Education Workshop, MSMS Headquarters, East Lansing

Oct. 11-12-13 — University of Michigan Medical Center Alumni Conference, Ann Arbor

Oct. 20-26 — National Community Health Week

Oct. 23-24 — Michigan Tuberculosis and Respiratory Disease Association Annual Meeting, Hayes Motor Hotel, Jackson

Oct. 24 — Michigan Thoracic Society Annual Meeting, Hayes Motor Hotel, Jackson

Oct. 30-31 — Symposium on Neuroendocrinology of Human Reproduction, McGregor Conference Center, Wayne State University

Nov. 6 — The Council, MSMS Headquarters, East Lansing

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

Dec. 1-4 — AMA Clinical Convention, Miami Beach

Dec. 11-12-13 — 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing

Dec. 18 — The Council, MSMS Headquarters, East Lansing

May 21, 1969 — Annual Muscle Symposium — Wayne County Medical Auditorium, Detroit ☐

WSU Reproduction Seminar, Oct. 30-31

Harper Hospital and the Wayne State University School of Medicine will sponsor a two-day symposium on the "Neuroendocrinology of Human Reproduction" October 30-31, in the WSU McGregor Center.

Specialists will offer biological and clinical perspectives on the physiology and pathology of reproduction. Program chairman is Harold C. Mack, M.D. For further information contact Symposium on Human Reproduction, Wayne State University, 100 West Kirby Avenue, Detroit 48202. ☐

PONTIAC ART SHOW TO BENEFIT RESEARCH

The Research Foundation of the Pontiac Providence Hospital Medical Staff will present its 2nd Annual Art Exhibit at the Adeline Fisher Center, Friday, October 11, from 10:00 a.m. - 5:00 p.m., and Saturday and Sunday, October 12 and 13, from 10:00 a.m. - 10 p.m.

Included will be the work of well known and amateur Michigan artists, displaying oils, water colors and ceramics. ☐

MHC Placement Services Helps Locate 850 Doctors In Michigan in 15 Years

In its 15th year of operation, the M.D. Placement Service of the Michigan Health Council has been responsible in part for the placement of more than 850 doctors of medicine in Michigan. In recent years placements have averaged approximately 55. In the period from July 1, 1967 to June 30, 1968, sixty-two M.D.s were placed.

All of the usual activities in the Placement Service which take place in the first six months of the year have been completed. These include revision of the rosters and a survey of all communities registered with the Service to bring the opportunities up to date. At the same time, all of the M.D.s registered have been contacted to determine if they still wish to receive placement information.

The list of communities needing doctors is ever increasing. More than 140 now are in need of at least one family physician, and over 60 communities are searching for medical specialists. Several communities in need of doctors have developed special brochures under the guidance of, or in cooperation with, the Michigan Health Council. These publications have been distributed to physicians registered with the Placement Service.

In cooperation with the Michigan Tourist Council, a full-page advertisement was placed in the Student AMA Journal, *New Physician*. Response was very good, and the ad was repeated in the publication. We also arranged to have the advertisement placed in *Physician's Management,* a publication that reaches family physicians throughout the United States. The magazine has run the advertisement on numerous occasions as a public service to doctors and to the Council. The ad also has been placed in all of the magazine's specialty publications. More than 300 replies have been received as a result of this national campaign. The first doctor to locate in Michigan as a result of this program is in general practice in Sturgis.

Consumers Power Company, because of its interest in the economic development of rural Michigan and its recognition of the need for an adequate number of doctors, has taken a keen interest in assisting the Michigan Health Council in promoting Michigan as a place to practice medicine.

The Company developed an outstanding brochure that describes the vast opportunities for family doctors. Copies are available in quantity to Michigan physicians who are interested in sending the brochure to medical students, interns and residents along with a personal message inviting them to come to Michigan.

The Upjohn Company of Kalamazoo has continued its much appreciated financial support of the Council's Placement Service — which is rated by doctors using it as the most helpful in the Nation.

The Dentist Placement Service continues to grow, and the number of opportunities for dentists throughout the State has tripled in the past two or three years. □

HEART, CANCER, STROKE NOW CLAIM 7 OUT OF 10

Heart disease, cancer, and stroke, taken together, claimed 1.2 million American lives in 1965 — about 7 out of every 10 deaths in this country.

Heart disease — or, more technically, the cardiovascular-renal diseases — can be divided into three major categories: (1) strokes — damage to the blood vessels affecting the central nervous system; (2) diseases of the heart and blood vessels serving the body, including rheumatic fever, arteriosclerosis, high blood pressure and hypertensive heart disease; and (3) kidney disease, including chronic nephritis and renal sclerosis. Heart disease and stroke accounted for over 900,000 deaths in 1965.

Uncontrolled cancer growths, which invade and destroy living tissue, occur in a variety of forms in many different body locations. In 1965, cancer caused nearly 300,000 deaths. Unless cancer rates are cut, about one out of every four people alive in the United States today can expect to develop cancer at some time.

— Quoted from
Reference Facts on Health,
Education, and Welfare,
U.S. Department of H.E.W. □

Would Alert Public To Health Hazard Posed by Chiropractors

The AMA House of Delegates in San Francisco adopted a resolution which urged all state and county medical societies to alert the general public to the health hazard posed by the cult of chiropractic. The resolution pointed out that physicians have a direct and personal responsibility to provide the best scientific medical care and to protect the health of the public.

The resolution called attention to the AMA's statement of policy which notes in part that:

> *"It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and rigid adherence to an unscientific approach to disease causation.*
>
> *" . . . The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results."*

The resolution urged state medical associations and component medical societies to adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression.

SMOKING-HEALTH POSTERS AVAILABLE FROM MSMS

Physicians interested in communicating an anti-smoking message to patients can consider displaying a striking poster which reads, "1,000 Doctors Have Quit Smoking Cigarettes (Maybe they know something you don't)."

Posters are available from MSMS Headquarters, P.O. Box 152, East Lansing.

Smoking Council Provides Program Guidance for PTAs

A new program planning guide, designed to help discourage smoking among children, is being distributed in September to the 2,200 local PTA units in Michigan.

The guide was developed by the Michigan Congress of Parents and Teachers in cooperation with the Michigan Council on Smoking and Health.

The suggestions are designed to help PTAs inform the parents of school-age children about the dangers of smoking and to discourage young people from starting to smoke.

The project also seeks to encourage parents to examine their smoking behavior and its possible influence on children, "the great imitators;" to urge parents' support of school programs dealing with smoking and health; and to urge parents to cooperate with local health organizations in solving the problem of smoking.

Mrs. Mary Palmer, of Parma, is health chairman for the Michigan Congress.

The Michigan Council on Smoking and Health consists of 16 member organizations, including the Michigan Congress and the Michigan State Medical Society.

State Physicians On AAP Program

Seven Michigan physicians will participate in the 37th annual meeting of the American Academy of Pediatrics, October 19-24 in Chicago.

Stuart M. Finch, M.D., of Ann Arbor, will serve as chairman of a general session panel, "Sex Education — The Parents' Role," Tuesday, October 22.

Participating in the Monday, October 21, scientific program of the Section on Surgery will be James R. Lloyd, M.D., of Detroit; and Edward S. Tank, M.D., George E. Bacon, M.D., and George H. Lowrey, M.D., all of Ann Arbor. Doctor Lloyd will conduct a session on Gastrointestinal Perforations in the Newborn: Etiology and Management, and the three Ann Arbor doctors will lead a discussion of Surgical Management of Thyrotoxicosis in Children.

Reuben Meyer, M.D., and Allan Done, M.D., both of Detroit, will participate in the annual meeting of the American Association of Poison Control Sessions during the Monday, October 21, session. Doctor Meyer will take part in a program on Dialysis for Toxins, and Doctor Done will participate in a session on Hallucinogenic Drugs.

The Academy's annual meeting includes general sessions, seminars, section meetings, special sessions, clinical conferences, a business meeting and technical exhibits. It will be held at the Palmer House in Chicago.

Pathologists Award Two $500 Fellowships

The trustees of the Michigan Society of Pathologists have approved the donation of two $500 junior college fellowships to Michigan students planning careers in medical technology.

The funds are to be administered by the National Committee for Careers in Medical Technology. The two students so honored this year are Barbara J. Nelson, 5700 Brockway, Saginaw, who has been attending Delta College, and Carol Lynn Shoksnyder, 6525 Merriman, Garden City, who has been attending Schoolcraft College at Livonia.

College Counselors Thank MSMS, Want More AMA Career Books

MSMS has launched a new effort to provide new accurate information to college counselors about careers in medicine and the many health vocations.

Among the MSMS activities in this field has been the distribution recently of copies of the AMA handbook "Opportunities Unlimited" about health careers.

The response from the college counselors has been gratifying.

In part, the reply from Thomas R. Plough, Dean of Students at Alma College, said, "I feel this AMA handbook will be of value in our career information file. Please send me four more copies. Your concern and interest in this matter is greatly appreciated."

"With our growing biological science and premedical curricula it would be most helpful if you could forward 10 copies of your 'Horizons Unlimited' book for interested students. It would be most helpful if other vocational areas could produce such a useful pocket-book as has the medical profession. With your leadership in this field, others might follow," wrote Michael J. Wiener, counselor at Michigan Technological University at Houghton.

"The pocket-book 'Horizons Unlimited' will be of great value to us in our work with young people," wrote Jean M. Phillips, Director of the Northern Michigan University Counseling Center. The letter asked for 10 more copies for interested students.

Flashback to County Programs 50 Years Ago. . .

What were county medical society meetings like back in the period from 1904 to 1924?

What subjects did the scientific meetings deal with?

These questions can be answered, in part, by reading the "Medical History of Muskegon County," written by William M. LeFevre, M.D., of Muskegon. It was back in 1904 that MSMS Councilor William T. Dodge, M.D., traveled from Big Rapids to Muskegon to help the Port City doctors organize a component society. Prior to that, the Muskegon physicians were formed into the Physicians Mutual Aid and Protective Association. There were 47 physicians in Muskegon County in 1904.

Doctor LeFevre examined the records for the first 20 years of organizational activity, 1904 to 1924, and wrote:

"A total of 244 scientific papers were presented before the Society over this period, mostly by the members themselves, but about one-quarter were by outstanding physicians from other parts of Michigan and near-by states.

"Nineteen percent of these papers dealt with surgery and its allied branches, such as fractures, thyroid disease and gynecology. Thyroid disease was considered surgical at that time because no medical management had as yet been introduced.

"Tuberculosis and lung disease were big factors in the everyday practice of the physician and they were the subject of thirteen percent of the papers.

"Infection other than tuberculosis naturally was of great interest and accounted for ten percent of the papers. This section of the medical field was naturally large, due to the many mill accidents and natural traumatic mishaps. Iodine and carbolic acid were the chief antiseptics in general use, but many a case recovered after the generous use both internally and externally, of the next best antiseptic, whiskey.

"So the above mentioned categories accounted for almost half of the scientific papers of this period and the other half included such other subjects as are of paramount importance to the doctor of today such as pediatrics, therapeutics, neurology, laboratory tests and their use, cardiology and many others."

Hope U-M Postgraduate Center Will Be Ready in Early 1969

With the summer construction strikes over, work has resumed on the $2 million postgraduate medicine center on the grounds of the University of Michigan Medical Center in Ann Arbor. Begun in the spring of 1967, the two-level building will hopefully be complete in January or February of 1969.

THE MAIN TEACHING facility in the building will be the 520 person continental-style Dow auditorium. There will also be a 170-seat lecture hall with a stethephonic communications system between each seat. This system will be used in the teaching of cardiology.

In addition there will be three 50-60 seat classrooms and at least two seminar rooms with capacities for 20-30 people. Also a large exhibit and demonstration hall will be a part of the new center, as well as seven overnight rooms for guest faculty members who frequently take part in the continuing education program.

During the 1968-69 academic year, the University will offer slightly more than 40 courses for physicians and other health personnel.

The importance of continuing education for allied health personnel is outlined by Harry A. Towsley, M.D., director of the postgraduate medical education program:

"In this day of the need for supporting personnel in all medical fields, these courses will give them an opportunity for continuing education programs, helping them to help the doctor give patient care."

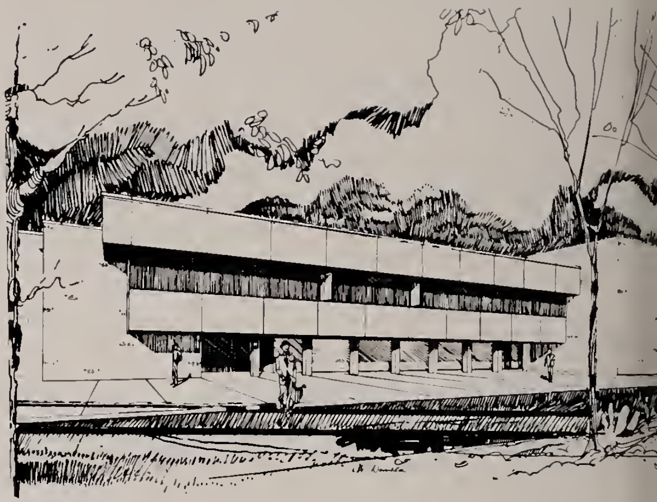
"IN PLANNING THE programs for continuing medical education for physicians," Doctor Towsley says, "every effort has been made by the clinical and teaching members of the faculty to sort from the overwhelming volumes of biomedical literature, that information which is applicable in the day-to-day care of patients."

"We start from where the physician is," he added, "instead of teaching him simply what the researcher wants him to know."

Physician courses are of two kinds at the postgraduate education center: the short, intensive course which runs from 1 to 3 days; and the drive-in course which consists of weekly classes held over a period of many weeks.

THE NEW BUILDING will increase the Potential of the postgraduate medicine program in three basic ways, according to Doctor Towsley:

It will permit an expansion of already existing programs and serve as a catalyst for developing new ones.



It will greatly enhance the teaching potential of the post-graduate program because of extensive planning for flexibility in the use of audio-visual aids.

It will serve as a regional meeting place for physicians and other health personnel groups.

Physicians who want further information on the post-graduate programs can write to the Department of Postgraduate Medicine at the University of Michigan Medical School in Ann Arbor.

H. A. Towsley, M.D., center, U-M director of postgraduate medical education, reviews building plans with Ralph E. Lewis, left, and Robert K. Richards, right.

Observations about Health Platforms Adopted by GOP and Dem Conventions:

BY WASHINGTON OFFICE
OF THE AMA

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

THE REPUBLICAN PLATFORM also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of Medicare care," the Democratic platform said.

WITHOUT BEING SPECIFIC, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of Medicare or Medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Donald E. Wood, M.D., Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; John R. Kernodle, M.D., Burlington, N.C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

THE AMA STATEMENT expressed hope that the next federal Administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

The AMA emphasized the desirability of health programs being partnerships among private enterprise and federal, state and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety, and education of physicians and allied health personnel.

CONCERNING HEALTH CARE costs, the AMA said:

"We believe that programs to increase the production of medical and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward a health in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as Secretary, with overall responsibility for all federal health programs, so that maximum effectiveness may be attained.

"We have always maintained that high-quality medical care should be available for all Americans, including those who need assistance in meeting the costs of such care. . . Firmly convinced that adequate health insurance coverage is the choice mechanism for the financing of quality health care costs, we suggest that the country embark on a program of tax credits for health insurance premiums. Under such a plan, all individuals and families would be encouraged to provide themselves with health care cost protection, with those in financial need receiving the greater amount of tax credit on a graduated basis."

SOCIO-ECON

Michigan Medicaid Statistics Offered

Effective October 1, 1966, Michigan Blue Shield was selected formally by the Michigan State Department of Social Services to administer certain benefits of the Title XIX (Medicaid) program for the State, and began immediate servicing of the program. Unlike Title XVIII (Medicare), which is financed by Social Security funds and is a national health care program for persons aged 65 or more, Title XIX (Medicaid) is financed in various formulas of matching funds for various health care services for certain categories of people as determined by the various states. Its benefits vary from state to state but generally pay the full cost of medical service.

In Michigan, Title XIX health care is furnished to two groups of persons. Group One, the "Categorically Needy," is composed of persons who receive financial aid under the State "categorical" programs of Aid to the Blind, Old Age Assistance, Aid to Families of Dependent Children and Aid to the Disabled. Group Two, the "Medically Needy," is made up of persons who support themselves without financial assistance in non-emergency circumstances, but who are judged unable to finance certain medical needs. Their eligibility is this state is determined by a formula based upon income, property and other assets, and family size.

In Michigan, Group One, the Categorically Needy, peaked at 243,732 persons in November, 1967. The pool of persons eligible for Group Two, the Medically Needy, is estimated at 375,000. Therefore, Michigan Blue Shield's total responsibility for service under Medicaid involves 625,000 people, or almost as many persons as the total populations of Lansing, Flint, Grand Rapids and Saginaw.

Table 1 gives an account of the number of services and claims paid during the period from October 1966 to December 1967.

TABLE 1
TITLE XIX — PAID CLAIMS AND SERVICES
IN MICHIGAN

Paid Period, October, 1966 - December, 1967

Group I	**Amounts**	**% of Total**	**Number of Services**	**% of Total**	**Average Cost Per Service**
Old Age Assistance	$ 2,984,979	20.17%	782,070	33.89%	$ 3.82
Aid to Blind	145,882	0.99	25,242	1.09	5.78
ADC Adults	4,105,906	27.74	600,327	26.02	6.84
ADC Children	2,498,705	16.88	348,782	15.12	7.16
Aid to Disabled	2,733,114	18.47	438,556	19.00	6.23
Total Group I	$12,468,586	84.25%	2,194,977	95.12%	$ 5.68
Total Group II	$ 2,330,923	15.75%	112,610	4.88%	$20.70
Total Group I & II	$14,799,509	100.00%	2,307,587	100.00%	$ 6.41

Manufacturing Rising in State

Manufacturing in Michigan, after posting only modest gains for 1967, is on the upswing again.

The Seventh Federal Reserve District, using an index based on industrial consumption of electric power, reports that the state and other centers located within the reserve district show signs of recovering from production decline.

Saginaw, last year, was the only Michigan city to record a production increase greater than the year before. Rapid expansion of capital expenditures by business in 1965 and 1966 produced massive inventories. This resulted in production "adjustments" in 1967. The slump in automobile sales extended the adjustment to consumer durables.

The five states within the district — Illinois, Indiana, Iowa, Wisconsin and Michigan — account for 23 per cent of the nation's manufactured products. Production of durable goods within the district total some 69 per cent of output. Prosperity is strongly influenced by business expenditures for new plant and equipment.

Manufacturing has grown faster in Detroit, Grand Rapids, Jackson, Muskegon and Saginaw

(Continued on Next Page)

than in the United States as a whole: seven per cent annual growth between 1960-66 compared to six per cent for the nation. The growth is attributed largely to production of automobiles and related equipment.

Michigan produces 40 per cent of the country's motor vehicles and more than a third of the district's production of durable goods. The auto industry, however, is strongly cyclical.

Michigan's production of non-durables, while showing a slower growth rate, exhibits greater growth stability. Food products and chemicals account for more than half of the state's manufacture of non-durable goods. More than 40 per cent of Battle Creek's output is in food products while almost 60 per cent of Kalamazoo's manufacturing is in chemical and paper products.

Although neither city has enjoyed the rate of manufacturing growth experienced in durables, both have shown stable increases of about six per cent per year. □

Sees Medical Schools Graduating 10,000 Each Year by 1975

"Today, the United States has a physician population of approximately 300,000. This includes approximately 185,000 physicians who are in private practice; about 55,000 who provide medical service in other than private practice, (as full-time members of hospital service staffs or medical school faculties, in administrative, laboratory or preventive medicine, or in research); and more than 45,000 who are completing hospital internship or residency training. The remaining 15,000 are either retired or not presently practicing medicine."

"By 1975, at least 350,000 physicians will be required to meet the nation's growing needs for physicians, according to the United States Public Health Service. It estimates that physicians will be graduating at the rate of 10,000 a year by then — a rate nearly 2,500 greater than that achieved in the 1965-66 school year when 7,574 physicians (an all-time high) were graduated."

"To provide the additional physicians which are necessary, the nation's medical schools are concentrating on accelerating their already-impressive expansion programs. Approximately 20 new medical schools now are envisioned, including 13 which already are in various stages of development."

—*AMA Horizons Unlimited*

Forecast Trends In State Economy

The Federal Reserve notes that local interruptions in manufacturing activity have pronounced effects on industrial output. In 1967, the Detroit automobile strike and the summer riot contributed to overall decline in productivity.

On the basis of technical reports prepared by the State Resource Planning Division of the Michigan Department of Commerce, the following observations can be made:

1. Total employment in Michigan is forecast to rise from 2,740,500 in 1960 to 3,960,000 in 1980, an employment growth of 44 percent. On an annual basis, this would constitute an increase of 1.9 percent per year from 1960 to 1980. Thus Michigan's growth would parallel the national rate.

2. Medical and other professional service employment is forecast to rise by 539 thousand or 164 percent from 1960 to 1980.

3. With the exception of apparel manufacturing which is forecast to rise 167 percent, manufacturing employment is expected to grow moderately and in some instances (e.g., food products, textile mill products, lumber and wood products) to experience declines.

4. Michigan will be called upon to turn out more services relative to goods in the 1970's with travel, education, medical and hospital services absorbing more cents to each consumer dollar.

5. Medical and other professional services, public administration, finance, recreation, trade and business services will be the rapidly growing fields of economic opportunity from now to 1980.

6. From 1960 to 1980, employment in medical and other professional services are expected to increase at rates ranging from 147% in the Detroit 7 Area to 198% in the Jackson area.

7. Michigan will grow from 7.8 million in 1960 to 9.9 million persons in 1980 or 26.1 percent according to forecasts prepared under the State Resource Planning Program.

8. With regards to changes in the age composition of the work force, projections indicate an absolute decline in the number of persons available in the labor force in the age groups between 35 and 50 years of age for 1980 as compared with 1960.

For a more complete analysis details may be studied in "Michigan's Future, It's Population and It's Economy," Technical Report Number 10B, State Resource Planning Program, Michigan Department of Commerce.

AUDITOR OFFERS:

Year End Tax Planning

BY KENNETH B. KNOSTMAN, C.P.A.
LANSING

Doctors of Medicine became subject to SELF EMPLOYMENT TAX for years ending on December 31, 1965, and each year thereafter.

The 1968 rate, including Medicare, is 6.4% of $7,800.00 for a maximum tax of $499.20. These rates are currently scheduled to increase progressively to 7.8% by 1987.

ARE YOUR PROFITS particularly high this year? If so, consider the following:

1. Make needed repairs before year end, and deduct the cost.
2. Stock up on routine supplies. (Drugs, tape, bandages, etc.)
3. Delay billing of patients until 1969.
4. Pay year end bonuses before December 31.

(Should you expect 1969 to greatly exceed 1968, then, reverse the above procedures. Remember, tax savings are accomplished by a "level income" — avoid extreme highs and lows.)

* * *

ARE YOU CONSIDERING the purchase of x-ray, or other expensive equipment with a useful life of at least six (6) years? If so, plan the year of your purchase in order to reap the following tax benefits:

1. An extra 20% depreciation can be taken on the first $10,000.00 cost ($20,000.00 on a joint return). This extra deduction of $2,000.00 on a single return ($4,000.00 on a joint return) may be taken regardless of how late in the year the equipment is put into service.
2. The 7% investment credit would also apply to this purchase (8 year useful life required for full benefit — 6 year life would allow 7% credit on 2/3 of your cost). Again, the credit applies no matter how late in the year your purchase is made.

Example: You buy, and put into service, the $10,000.00 machine in December. You may deduct $700.00 DIRECTLY FROM YOUR TAX.

CONTRIBUTIONS OF appreciated property, rather than money, can save tax dollars.

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Measurement of Quality and Quantity Of Medical Services

ABSTRACT: Alternative methods of measuring quality and quantity of medical services are reviewed and two methods of measurement under development at Michigan Blue Shield are described.

BY GORDON TAAFFE, Ph.D.
MICHIGAN MEDICAL SERVICES

Objectives of medical care are to relieve human suffering and/or to prevent conditions which lead to suffering. Evaluation of the ways and means that these objectives are met is a necessary part of the medical profession. Self evaluations by the medical profession provide standards of care and upgrade medical services generally. Economic pressures resulting from increased demands and rising costs of medical care necessitate efficiency and cost-benefit analyses of the organization, administration, and delivery of medical care. Basic to these evaluations, however, is the measurement of quality and quantity of medical services.

Sidel[1] describes three ways to measure medical care. They are: 1) to test the knowledge and skills of physicians, 2) to judge methods and practices of physicians by reviewing their records or by observing their work, and 3) to evaluate the end result of the physician's effort, the patient. Each method has advantages and disadvantages. Testing the knowledge and skills of the physician is experimentally the most reliable method of measurement of the three described and in a statistical sense, the most valid. The physician's tested knowledge is compared with a vast amount of medical fact and objective assessments of discrepancies between fact and test results can be reliably made. This kind of measurement is common to medical training and later is a part of specialty boards and other certifying agencies. Testing medical students and physicians has reached a high degree of sophistication and no one has much to quarrel with over this method of measurement.

IT DOES NOT NECESSARILY follow, however, that the well-tested physician who tests well will in fact perform better in practice than will the physician who tests poorly. That is to say, training performance does not necessarily predict subsequent on-the-job performance. Good training is a necessary condition for medical practice but it is not a sufficient condition for excellence in medicine. It is not known, for example, whether the well-trained physician will keep up with the advances of his profession, use sound judgment, or in other ways be a "good doctor." While assuring high standards is an admirable characteristic of the medical profession, good training is not a sufficient index of uniform excellence of medical services.

Reviewing the records of a physician by his peers is a common method of measuring quality of hospital care. This method brings into play many qualitative assessments of various medical procedures and practices. The diversity of medical care and the idiosyncrasies among physicians create wide variability of standards of care, a factor which complicates the reviewing process. The fact that the ultimate responsibility for the care of a patient rests with the attending physician permits the establishment of a variety of standards of care rather than a uniform standard. In addition to these weaknesses in measuring quality and quantity of medical services, the review phy-

This is another in a series of Michigan Blue Shield articles on Utilization Review. The author, Dr. Taaffe, is Associate Director of Utilization Review research staff. He has conducted psychological and educational research studies before coming to Blue Shield. He is also an adjunct professor of psychological statistics and research methods at the University of Detroit. Doctor Taaffe is a member of the American Psychological Association and is listed in Who's Who in American Education and in American Men of Science.

—Louis F. Hayes, M.D.,
Vice President,
Medical Affairs Division

sicians are faced with a large volume of cases to review, a condition which often leads to either reviewing in a superficial way or to selecting extremely atypical cases for review.

HOME AND OFFICE medical services, which comprise the bulk of most physician's medical practice, lie entirely outside the pale of utilization review. Gross malpractice may come to the attention of local medical societies but peer review of routine home and office care is noticeable by its absence.

Finally, going to the patient to measure quality and quantity of medical services presents several problems. To have patients appear before a panel of review physicians is impractical except for exceptional cases and asking the patient about the care he received does not often yield reliable information. Patients that expire do not, of course, permit review. Patient review is the least promising way of measuring medical services of the three methods described.

In contrast to the methods of measuring quality and quantity of medical services just described, Blue Shield is developing two methods of measurement. The two methods capitalize on the voluminous data on health care that Blue Shield accumulates. The first method is computer-assisted peer review. Using this method, the computer will identify atypical cases of medical care for review by a panel of physicians. Computer identification of atypical cases will be based on norms of care for particular illnesses and on medical procedures followed in the treatment of the illness. Norms of care with respect to length-of-stay, post-operative length-of-stay, and other similar variables will be derived from records of utilization while procedures typically followed will be based on criterion indices established by the medical profession. For example, distributions of selected characteristics of medical services will be determined and parameters of the distribution computed. Modal frequencies, medians, and arithmetic averages, ranges, and variances of care will be computed. The several quantitative measurements together will define a domain of medical care, for example pneumonia. Quality of care will be evaluated with reference to these normative criteria. Causes for review of a case will be based on cases which fall in the extremes of normative distributions or which have atypical procedures or both. Constraints with respect to age and sex of the patient as well as severity and complications of the illness will be incorporated into the automated reviewing procedure. Blue Shield records of utilization will serve as the primary data for analysis.

For Your Library

Copies of "A Century of Service in Medicine," published as a Centennial highlight by MSMS, are still available for cost, $2.00. The book, bound handsomely in blue, was written by Wm. J. Stapleton, Jr., M.D., of Detroit, the MSMS Historian. To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing, and enclose a check.

WHILE THE COMPUTER-assisted peer review is oriented towards case studies, pattern and profile studies are directed more toward the measurement of quality and quantity of medical care in the community. This second method of measurement under development at Blue Shield will seek to describe characteristic medical utilization in the community. In these studies, profiles of providers and users of medical services will be established in preliminary studies and patterns of characteristic usage will be under continuing analyses. Quality of medical services will be established on a demand-resources basis as well as on quantitative and qualitative characteristics of providers. Profiles for hospitals, for example, will describe the distribution of hospitals in Michigan by community, number of beds, average number of patients, type of hospital, and other similar characteristics. Relevant variables for physician profiles will be such characteristics as training, specialization, type of practice, professional appointments, and so on. Patient characteristics will be age, sex, family structure, insurance benefits, geographic location, and other similar variables. While profile studies will be largely descriptive, pattern studies will seek to link together the patient with his physician and hospital. Characteristic medical utilization will be the objective of the pattern and profile studies.

Evaluation of current allocation of medical resources against demand patterns for those resources may offer economic insights as well as indices of quality of medical care. Pattern and profile studies will be quite varied and should offer comprehensive analyses of medical utilization in Michigan.

Durbin[2] describes quality of medical care as "the method of determining how close observations of care meet prior expectations of care." Blue Shield will establish "prior expectations" on a statistical basis and will review atypical cases professionally. Both Blue Cross and Blue Shield records of utilization will be analyzed. The records represent not only hospital care but also clinic and home and office medical services. These methods of measurement of quality and quantity of medical services appear to be the most appropriate review of medical services for Blue Shield. It goes without saying that these methods of measuring quantity and quality of medical services are dependent upon vast amounts of medical utilization information and on computers with tremendous data processing capabilities. Blue Shield has the utilization information and computers and a research staff is presently attempting to cope with problems of analysis.

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NINE NEW CANCER FILMS OFFERED MD AUDIENCES

Nine new 16 mm color and sound films on cancer are now available free of charge for viewing by physician audiences, the American Cancer Society announced recently.

The films are entitled as follows: "Cancer of the Skin;" "The Diagnosis and Management of Cancer of the Colon and Rectum;" "Cancer in Children;" "Uterine Cancer: Diagnosis and Management;" "Oral Cancer;" "Hormone Therapy for Advanced Cancer;" "Tumors of the Major Salivary Glands;" "Early Diagnosis and Management of Breast Cancer;" and "Cancer of the Stomach."

Groups of physicians who want to view the films can obtain them from their local unit of the American Cancer Society. ☐

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Industry, Physicians, Legislators, Others Seeking Solutions to Air Pollution

BY JULIE ORWIG
LANSING

—In 1952 and again in 1962 a thick, impenetrable smog fell over London. The first time, the stifling seige last two weeks, the second only four days. However, the results in both instances proved the same when Mother Nature finally and sympathetically cleared the air — the city had suffered extensive property damage, but more importantly, soaring death rates were reported during these brief periods.

—In New York City, Ernest L. Wynder, M.D. and Dietrich Hoffman, M.D., of the Sloan Kettering Institute revealed the results of a startling experiment. For six weeks the doctors kept a truck, built to act as a human lung, parked in Herald Square. The truck sucked in thousands of cubic feet of air and ran it through filters. At the end of the six weeks the doctors scraped a thick residue from the filters. Reducing this to its chemical components, they put it on the backs of mice. Eventually, 90% of the mice developed cancer.

—In 1961 a poll revealed that in Los Angeles, where the secret of photochemical smog had been discovered, doctors have told over 10,000 patients to leave the area for their own good.

Certainly these are some of the more dramatic examples of the problems presented by air pollution. However, it has taken just such startling revelations and too often disasters to finally awaken man to the fact that he is creating a virtual sewer from the air he breathes.

Edward Edelson and Fred Warshofsky, in their book, *Poisons in the Air,* report "that the history of air pollution is largely a tale of two cities — London, where the air is historically worse than any other place on earth, and where the greatest air pollution disaster ever recorded occurred; and Los Angeles, which introduced the world to a new type of air pollution, then blazed a trail toward cleaning it up."

BUT AIR POLLUTION is no longer simply a historical problem experienced by a few of our largest cities. Air pollution is here and now — in Michigan. And it is everyone's enemy whether he lives in the city or surrounding countryside. And it is a problem to be reckoned with as technology threatens to spew even increased amounts of poison into the atmosphere while urban living cramps greater numbers into smaller areas.

In 1960 statistics gathered by a U.S. Senate committee confirmed that 43 million people lived in cities with "major" air pollution problems. Another 30 million reportedly lived in areas with problems described as "moderate."

The idea that polluted air could cause disease is by no means new. Medical history reports that at one time cholera, smallpox, diptheria, scarlet fever, yellow fever, malaria and even syphilis were all erroneously thought the result of "bad air."

Now medical science is actually beginning to find that our respiratory systems can be greatly effected by polluted air. But the smoke is only beginning to clear on the relationship between pollution and respiratory disease. Most medical authorities will now admit, however, that there is at least some relationship between the two.

MORTALITY AND MORBIDITY rates seem to support this belief. In the "Journal of Environmental Health," Mel Weisburg, M.D , of the American Medical Association, reports that lung cancer mortality is twice as high in cities as in rural areas, more or less proportionate to the size of the corresponding population. Death rate sta-

Photo, Courtesy of Michigan Department of Public Health

tistics from London; Donora, Penn., and the Meuse Valley in Belgium, where smog disasters have occurred, add further evidence that polluted air is detrimental to the respiratory system.

The extent to which air pollution affects respiratory disease is unknown. One thing is certain, however. Both pollution and this type of disease are on the rise. Just how proportionately the two are related is the dilemma of physicians, government officials, concerned citizens — all those who are attempting to do something to clean up the mess.

OFFICIALS ARE NOT dealing with a disease such as malaria, now known to be caused by five or more species of parasitic protozoa and transferred to the human blood by mosquitoes. The exact causes of asthma, chronic bronchitis, emphysema and lung cancer are unknown.

Government officials find it difficult to move in, as in the case of malaria, and tell a man to clean up the swamp behind his home because it is a breeding place for malaria carrying mosquitoes. With respiratory disease it is not easy to force industry and individual citizens to install emission devices or to stop burning rubbish. The burden of proof lies with the scientist and researcher.

The old adage of "man or mouse" further complicates the case for science. It is virtually impossible to reproduce in the laboratory with any degree of certainty, the gradual effects which an ever-changing polluted atmosphere may have on a human being. Researchers are constantly reminded of the dangers involved in assuming a similarity between human and animal reactions to an experiment.

Much is also being done outside the researchers laboratory to further the cause of clean air. On the national scene the federal government passed the Clean Air Act (88-206) in 1963 which provided for federal grants amounting to $95 million to match local expenditures aimed at the control of air pollution. This contribution has been increased when two or more cities or states join forces in combatting pollution.

In 1965 an amendment (89-272) was passed giving the Secretary of Health, Education and Welfare the power to set emission standards for automobiles and trucks. Providing for the construction of needed research facilities, a total of $92 million over four years was authorized for studies of the problems of waste disposal.

As a result of this amendment newly installed devices on 1968 model cars will reduce hydrocarbon emissions by 60% and carbon monoxide emissions by 50%.

The federal House and Senate this year passed S-780, known as the Air Quality Act which authorizes $428 million over three years to continue and expand efforts of the earlier acts. Under this law states will be given the upperhand in abating air pollution with the federal government stepping in only if their efforts should fail. The law authorizes a two-year study of national pollution standards and will permit states to set their own goals in this area. The Secretary of Health, Education and Welfare is given the power to establish air quality regions and set up commissions to govern regions where air pollution overlaps two or more states or areas.

IN MICHIGAN, THE state legislators are protecting their authority from federal government intervention while at the same time helping to clean up Michigan air through the enactment of new laws.

In 1965 Acts 348 and 250 were passed by the 73rd Legislature. Act 348, known as the Air Pollution Control Act, provides for the creation of an Air Pollution Control Commission within the Department of Public Health. Under this act, the Commission is licensed to promulgate rules and regulations to control air pollution, to compel witnesses in complaint cases to attend hearings, to institute court proceedings against offenders and to provide inspection and approval of air cleaning devices. Act 348 was amended this year to provide that nothing in its content be inconsistent with federal regulations on motor vehicles.

On February 3, 1967, the federal Control Commission adopted a set of rules and regulations to be applied when a written complaint is filed with the Commission against a possible polluter.

Act 250, also passed in 1965, provides that industries may make application with the state tax commission for exemption from real, property, use and sales taxes on air pollution control facilities which they install. The procedures for obtaining such exemptions were further clarified in an amendment (Act 145) passed by the 74th Legislature.

THE LAWMAKERS ARE not the only people in Michigan who are helping to solve the problems of contaminated air. As the spokesman for and protector of the interests of industry, the Michigan State Chamber of Commerce in a recent report applauds the advances being made in correcting pollution.

The Michigan State Chamber, having sold legislators on the idea that incentives would produce better results than punitive measures, was instrumental in promoting the passage of the state act of 1965 which allows for tax exemptions for industrial installation of pollution control devices.

While it is hard to condone industry's reluctance to install air pollution abatement and control devices, still it is understandable. An investment in such facilities does not increase productivity and it does raise the cost of manufacturing.

Industrial agencies are beginning to accept their responsibilities in this area, however. Harold E. Thayer, Chairman of the National Association of Manufacturers Area Industrial Problems Committee, speaking at the National Conference on Air Pollution last December, reaffirmed the contention that industry needs economic incentives, in the form of tax credits, for the installation of pollution control facilities.

As easy as it is to find a whipping boy, industry alone is not responsible for the condition of today's air. Individual refuse burning, smoke from salvage operations and the automobile contribute their share to pollution.

IN THE CASE OF the automobile, the new 1968 exhaust-control additions will help the problem. More research and development are necessary.

On a positive note, Jay A. Bolt, professor of mechanical engineering at the University of Michigan whose present research deals with engines and air pollution, states that present gasoline-powered automotive engines can, at increased cost to the consumer, be further developed to meet any reasonable anti-pollution emission standards.

The Michigan Association of the Professions is concerned too about air pollution. The 1963 Congress of the Professions adopted a resolution which declared, "that MAP directly and in cooperation with its state organization members, support the passage of any necessary legislation to permit the health authorities of Michigan to rid the state of pollution in the air insofar as that can be accomplished by state authority and also that MAP join with other groups, of like policy, in programs of public education in the support of anti-air-pollution efforts."

The MAP resolution declared, in part, that "one of the greatest health menaces facing the people

of Michigan and particularly the residents of Michigan cities is polluted air." The resolution urged preventive action programs in the interest of better health.

It is apparent that industry, researchers, lawmakers and independent community groups are all beginning to take an active part in helping to clean up the air pollution mess.

BUT WHERE DOES the medical profession's responsibility lie in this area?

Ultimately, if air pollution is not controlled, doctors, by virtue of their profession, will have to accept responsibility in caring for the millions of people who will be affected. Hopefully, there will be no more London disasters.

The American Medical Association is taking an active role in the fight. Believing that air pollution is primarily a problem best solved at local levels, the AMA has done much to encourage and support local medical participation in community control activities. For example, the AMA added its support to the Los Angeles County Medical Association's efforts in assisting local authorities in setting up emergency alert levels for pollution and in supporting legislation dealing with auto exhaust and fuel oil burning.

Another function of the AMA is to provide liaison with public and private groups to represent the profession's interests in air pollution disputes. AMA committees have been largely responsible for the preparation of informational documents and statements on air pollution for medical, technical and lay groups.

THE AMA BOARD of Trustees in April, 1965, approved creation of the Joint American Institute of Architects-American Medical Association Committee on Environmental Health. It is hoped that through this committee environmental problems such as air pollution will be more effectively approached through architectural design and planning.

The Michigan State Medical Society House of Delegates has resolved to support and commend the state legislature for their passage of pollution acts 250 and 348.

California, Illinois and New York medical societies have all formerly adopted air pollution programs.

The ills of dirty air can only be cured through individual concern and participation — and this includes the concern and participation of Michigan's physcians.

The AMA's "Physicians Guide to Air Pollution" states, "The physician who advises patients to move on account of air pollution also has an interest in promoting air pollution control in his community. He has a stake in securing purity of air in the same way he has in other biological needs — food, drugs, water. While the control of air pollution may appear beyond the scope of his practice, the physician can contribute medical standards and informed leadership to the community effort."

The individual physician in his practice is concerned about the possible effects of pollution on his patients as he studies air pollution data published by local and other government agencies. And more and more doctors are taking an active part in efforts to clean up the present condition of the air.

MSMS PRESIDENT URGES DOCTORS BE INVOLVED IN ANTI-POLLUTION

"The most effective approach to air pollution problems is the grass-roots, community approach."

So declared MSMS President B. M. Harris in a recent editorial in *Michigan Medicine*. He wrote:

"As physicians we have a community responsibility both individually and collectively through our professional and civic organizations to accept the challenge of helping clean the air we breathe."

Doctor Harris urged every MSMS member "to familiarize himself with his community's regulations on air pollution and their enforcement."

The MSMS President also wrote, "The medical fraternity, the ultimate recipients of victims whose exposure has progressed to the symptomatic stage (at which point the only help may be palliative) has both the opportunity and responsibility to participate actively in programs now underway and to eliminate the various sources."

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Blue Shield Data Processing Nears 150,000 Inputs Daily

Michigan Blue Cross "went computer" in 1955, when it installed an IBM 705 to handle all data processing for itself and Michigan Blue Shield.

Blue Shield's own Data Processing Department came into existence shortly before the advent of Medicare in 1966. It has grown from an original four employees, who coordinated Blue Shield business with the Blue Cross Data Processing Center, to 264 employees involved in a completely separate and independent computer operation.

In June, 1966, Blue Shield took delivery of its first computer, an H200. Its computer staff grew to 78 trained specialists by October of that year, when the computer was transferred to the 17th floor of the Cadillac Tower Building.

Further expansion of the operation occurred when Blue Shield assumed administrative responsibility for Medicaid in December of 1966, and in the spring of 1967 the company began to computerize regular Blue Shield business. At this point the writing of statistical reports and checkwriting formerly done by Blue Cross were phased into the operation and 40 more keypunchers added to the staff.

Blue Shield Data Processing came to maturity in August, 1967, as a formally organized Group, complete with Planning & Control, Systems, Programming, Data Control, and Computer Operations departments. Today, the only joint work done between the Blues' two operations is the checking of Blue Shield's daily input against Unifile's enrollment information, and billing.

Low volume programs such as CHAMPUS are processed on keypunch cards. Programs as vast as MEDICARE are computerized. Eventually, all Blue Shield, Medicare and Medicaid pricing will be done by computer.

The use of Data Recorders not only saves 34% in operations expense for data conversion but results in greater speed in processing information, since the computers can read magnetic tape 60 times faster than cards.

Blue Shield's Computer Room, equipped with two H2200 computers with 65K (a tape-oriented system), plus the original H200 computer, handled a volume of 146,000 "inputs" daily during March of 1968, or 81,000 more daily inputs than during the same month in 1967. In addition, by means of a Digitronics Remote Terminal, a machine tied by direct line to Social Security Administration headquarters in Baltimore, Blue Shield transmits and receives Medicare information directly on magnetic tape.

At work in Blue Shield computer operation are Fred Hasson, Nick Kristo and Gary Chick.

While Blue Shield Data Processing is completely modern, plans are already being made for years ahead.

A utilization file of six million case histories is undergoing long term review by MBS to determine what medical services are being used, and how. Such case histories, properly authorized for use, may in the future furnish valuable emergency information about the past ailments, medications and doctors of a patient in a coma.

At this moment Data Processing is gearing to handle an estimated 383,000 inputs daily by 1975, including data concerning the prescription and dental services which are sure to come. This is one more aspect of a progressive modern company with an eye to future, as well as present needs. ☐

Many Colombian men and women, seeking help for themselves and their children, crowd at the docks when the Ship Hope docks to provide medical care.

Enteritis, Gastritis Among Leading Causes Of Death in Colombia

This article describes some of the experiences by Mary L. Cretens, M.D., Gladstone, during a two month rotation, while the Ship Hope was in Colombia. Doctor Cretens is director of the Delta County Department of Health.

My two-month Rotation on the Ship Hope at Cartagena, Colombia, provided an opportunity to observe a kaleidoscopic picture of several decades of medicine. Some areas of medical care were many years behind our own and others were more current. Many Colombian physicians were very receptive to new ideas, some not. It was revealing to see yourself and your reactions reflected in many of the local medics.

Improvisations were important and generally we lacked much talent in this field, although the Colombians were no better. The Colombians were used to letting repairs of equipment and housing go until the equipment or housing was no longer useable, then they would discard it, often with no replacements.

I was somewhat prejudiced, but I felt the Public Health — General Practice Rotation was the best. All physicians had duties both on and off ship, but the two above mentioned had more functions on land. As I had a combination General Practice-Public Health Rotation, I had ample opportunity to observe sick and well people alike. I was priviledged to visit all the health and sanitation facilities of the area. I worked in the Ship hospital and sick bay, the city hospital, the outpatient clinics, and even made home visits and treated patients in their homes. I had a variety of interpreters which learned from me and my predecessors much about medical counseling. They all promised to carry on the continuing land based program sponsored by the Hope. This program will offer service for several years in Colombia. The interpreters were very intelligent women, many from influential families, that could put their finger on the source or cause of health problems. Their interpreter work had drawn them closer to all the people in this two-class society.

The feelings of a true medical-speciality team soon developed among the Rotators and was fostered by quarters so small that if the beds were placed side by side, instead of stacked, there would be no room for walking through the room. The team spirit was helped further by the fine, large, well set tables in the dining room and the group "deck" sessions in the evening. Age of the practitioner made no difference, in fact the most active practitioner on our Rotation was the oldest.

Colombia is a very rich country in resources. Poor distribution of goods and lack of development has prevented the masses from having adequate food and housing (average annual income is $175.-00). There is an extremely high birth rate and 50% of the children are under 15.

The father most often claims little family responsibility for his children, so very few children are educated. This inadequacy of education leads to the crux of their health problems. For example, there is no conception of proper diet. Sweets, fat, and starch are often eaten almost exclusive of other foods. Lack of potable water, coupled with lack of knowledge of cleanliness, plus tropic heat makes for nearly 100% infestation with amoeba, ascaris and the like.

People often do not even know how to get medical help and when they do seek medical help, they must sometimes wait two days to be seen. The

MARY L. CRETENS, M.D.
GLADSTONE

serious cases are not sorted from the insignificant diseases and so the serious problems are not given priority. Often people will not seek the physician's help at all; they will only go to the druggist who dispenses everything but narcotics.

Important causes of death are enteritis and gastritis. Heart disease is relegated to the number four cause of death. One poor lady counted and saved 420 worms her one year old child had passed, but she never considered seeking medical help for the child until we visited her home.

Generally diseases were much the same as elsewhere, except for incidence and severity. Almost all diseases were complicated by malnutrition and anemia. For the physician interested in epidemiology there are many interesting areas; for example, great incidence of enlarged thyroids in a seacoast living people, and the reversion in adults of blood cell patterns similar to those of childhood.

The greatest challenge and opportunity to the Rotator comes in teaching or, as I like to see it, the exchange of ideas. Much can be done by making comparison of methods and arriving at possible alternatives to solve problems.

What is needed in a country such as Colombia is better education at all age levels and the training of more medical and especially paramedical personnel and retraining old personnel in new methods of prevention, diagnosis, and treatment. Generally the Hope is doing just that, so it continues to have lasting value as contrasted to most of our other foreign programs.

MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING AUGUST 31, 1968

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	11	22	264	919
Whooping Cough	37	99	321	744
Diphtheria	0	0	0	1
Mumps	108	179	13118	12963
Scarlet Fever & Strep Sore Throat	252	356	7293	9828
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	1	0	1
Hepatitis	167	135	1423	1310
Salmonellosis (Other than S. typhi)	56	44	455	356
Typhoid Fever (S. typhi)	0	0	0	6
Shigellosis	20	19	174	300
Aseptic Meningitis	17	7	54	38
Encephalitis	4	2	56	83
Meningococcic Meningitis	5	3	68	53
Influenzal Meningitis	1	7	37	41
Tuberculosis	218	240	1891	2001
Syphilis	373	413	3671	3820
Gonorrhea	1546	1279	11888	11220

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

LEGAL

State Appellate Court Ruled Hospital Records Admissible in Estate Suit

(Editor's Note: The following article is quoted from the AMA Citation newsletter of August 1, 1968, prepared by the AMA Law Department.)

In a proceeding to determine the validity of a will executed by a testator in a hospital a short while before his death, his hospital records were properly admitted in evidence on the issue of his mental competency. The records met the requirements of the Business Records Act, a Michigan appellate court ruled. An internist's testimony on the testator's competency was also properly admitted.

A hospital employee who was the custodian of records identified the records offered in evidence as those of the patient. He testified that the entries were made in the regular course of the hospital's business and that they were made at or near the time the will was executed. He also testified that the records, including the nurses' notes, were used by the physician in the course of the patient's treatment. The physician who treated the man also testified as to the hospital's procedures in keeping patients' records. He further testified that the observations of nurses and others were of particular importance in this case because the patient was suffering from acute cirrhosis of the liver. There were 15 nurses, as well as numerous laboratory and X-ray technicians associated with the patient's treatment. To have required the calling of each of those persons would not have served any useful purpose, since the records' reliability had been established.

The will's proponent objected to the internist's testimony as to the testator's competency on the ground that his opinion was based solely on the hospital records. However, the evidence showed that he had examined the testator a short time before he was admitted to the hospital. The internist was eminently qualified in his field and was Board-certified. He testified as to the significance of the laboratory data and the administration of drugs appearing in the hospital records, and of the extreme importance of the nurses' notes. He testified that, in a case of cirrhosis such as the testator's, he was particularly concerned about mental confusion as an early indication of the worsening of the patient's condition. He related the mental confusion to the level of blood ammonia which appeared in the laboratory reports and demonstrated that there was a progressive deterioration of the testator's condition. It would have been error to exclude the internist's testimony.—*In re Estate of Searchill,* 157 N.W.2d 788 (Mich., March 20, 1968)

Must Get Consent

BY THE AMA

Is it proper for a physician to discuss his patient's medical condition, disease or illness with the press?

According to the AMA Judicial Council's opinion adopted in November, 1967, a physician's obligation is to his patient.

However, a patient, by virtue of his position, may have an obligation to others such as stockholders or voters to whom he may be responsible. If such an obligation exists, the disclosure of health knowledge must come from the patient, not the physician. The physician should insure the medical accuracy of any authorized report.

In summary, it is the opinion of the Judicial Council that a physician may not discuss the patient's health condition with the press or the public without the patient's consent or, in the event of his incapacity, the family's consent.

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MICHIGAN MEDICINE

Public Seen Accepting Fallacies About Old Age, and Believing Them; Rules for Good Health Suggested

BY PETER HOHEISEL
DETROIT

The shaking hand, tottering gait, loss of memory and mental faculties — are these the necessary consequences of old age?

Are old people necessarily more susceptible to cancer, stroke, and heart disease?

Does age 65 mark the beginning of inevitable physical and mental deterioration?

An emphatic "no" is the answer to all these questions according to the results of 10 years' work by the American Medical Association's Committee on Aging.

"The sad reality is that the American public accepts certain fallacies about old age and lives by them," says Frederick C. Swartz, M.D., a Lansing physician who heads the AMA Committee on Aging. "People think that at 65 they've over the hill and then they give up. Of course that's nonsense."

THE MAIN CONCLUSION of the AMA Committee on Aging study, as expounded by Doctor Swartz, is that there is no disease entity or physical or mental condition that results from the passage of time.

"Age does no damage to any organ," explains Doctor Swartz. "It's the use you put it to that counts. Nor does age make you more susceptible to any specific disease, he continued. I tell patients who are over 30 and complaining about getting old that what they need is conditioning; that they're getting lazy," says the Lansing physician.

"Most people do not really use their muscles, and yet vigorous physical stress is necessary for normal body functioning," he continued. "In order for exercise to be effective, it has to stretch the muscle to the fullest.

"Osteoporosis, a common complaint of older people, is as preventable as polio if people would exercise and stretch their muscles and bones. Lack of exercise is also the fundamental reason behind the many fractured bones and hips in older people."

TO PREVENT SENILITY, Doctor Swartz recommends mental as well as physical exercise. "People should read something hard each day so that their mind has to work. The old saying holds true: 'What you don't use, you lose.'

"These are some of the things people can do," concludes Doctor Swartz, "so that they can live longer, feel better, and enjoy living."

ANOTHER MAN ACTIVE in working with old people is Hazen Price, M.D., chairman of the Michigan State Medical Society Committee on Aging. Doctor Price is medical director for 500 elderly people at the Arnold Home for the Aged in Detroit.

The MSMS Committee on Aging works closely with the Michigan Society of Gerontology in

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Peter Hoheisel is now a full-time graduate student at Wayne State University, after leaving the MSMS public relations staff in September.

physican-education programs so that doctors can know more about the environmental realities which affect an older person's health.

"For a long time physicians weren't interested in things like family situation, housing, and retirement when they treated old people," Doctor Price says. "Now we are encouraging physicians to look into these things for the total care of the individual person.

"We can't take care of a person only in respect to his heart disease; we must take a multidisciplinary approach, and the work of our Michigan State Medical Society committee has been to broaden the outlook and interest of physicians in this field.

"I would like old people to realize that even if they have a chronic disease there is always something that can be done about it, if only to make the person more comfortable with it."

WHAT ARE THE RULES for good health among older people? Doctor Price outlines three basic ones:

1) *Physical activity.* This helps the breathing, circulation, and digestion.

2) *Mental activity.* A person shouldn't think that he can't learn as he gets older.

3) *Useful work.* Inactivity breeds a lot of trouble.

With regard to useful work, Doctor Price believes that older people shouldn't just work to keep themselves occupied, but should be active in being useful to others. "When you lose your usefulness you become a fixture, not somebody important. There is nothing so rewarding as doing something for someone else."

When asked about successful adjustment to old age among the people he knows, Doctor Price replied that the key is in accepting the limitations of old age. "Those who don't accept the limitations are depressed, and never successfully adjust. Instead of doing what they can do, they brood about what they can't do."

Women, according to Doctor Price, adjust to old age better than men. He feels that this is because a woman's life has centered around the home, and with age her life style does not drastically change. Retirement for a man, however, is a radical change from what he has been doing.

THE CONCLUSION OF these Michigan experts on aging is that environment, heredity, and living habits are the main causes of the illness and deterioration, normally associated with old age, and that age 65 is no automatic sign of senility. ☐

Press Promotes Need for Doctors

Every week, Michigan newspapers voice their editorial opinions about various medical and health subjects.

Often these editorials deal with the need for physicians and often they describe efforts of the medical profession to recruit toward this same common goal.

GIFTED YOUNG PERSONS NEEDED

From The Mt. Pleasant Times-News

"There is something very special about a good doctor. In these days when so much emphasis is put on the common man and equality the instinct of survival dictates that when we get sick, we want no part of the common man.

"We want an uncommonly good doctor and good doctors are not created overnight. Moreover, it takes a person of certain aptitude and qualifications to make a good doctor.

"To hear some of the talk about how to increase the physician population, one would think that all that is necessary is to open the doors of the medical schools and herd the young people in for training.

"WHEN IT COMES to the disciplines of science, the good doctor enjoys a happy combination of a penetrating scientific mind and a compassionate consideration for his fellowman—attributes beyond the average person.

"Expanding the doctor population cannot be accomplished as rapidly as laws can be passed that create demand for medical services.

"The American Medical Association at its last annual meeting laid heavy stress on expanding medical school facilities and increasing the output of qualified medical practitioners. ". . . our resolve," states the AMA Board of Trustees, "should always be as it is now; to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated, and highly skilled physicians."

"GIFTED YOUNG PERSONS of ability will find a life of work in the medical arts highly rewarding, spiritually and materially.

"Those who enter this field should dedicate themselves to maintaining the high standards that the profession has established."

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Magnus H. Agustsson, M.D., 2025 W. Holmes Road, Lansing 48910

Henry A. Archambault, M.D., 35550 Michigan Ave., Wayne 48184

Juan Belamaric, M.D., 1400 Chrysler Expwy., Detroit 48207

You Chen Chen, M.D., Children's Hospital, Detroit 48202

Ilhan Conklu, M.D., 401 W. Greenlawn, Lansing 48910

Daniel Cowan, M.D., Dept. of Pathology, MSU, Col. of Human Med., East Lansing 48823

Jorge H. Day, M.D., 11204 Glenfield, Detroit 48213

Leonard E. Ellison, M.D., 3800 Woodward Ave, Detroit 48201

Jerry S. Fagelman, M.D., 27841 Adler, Warren 48093

Richard F. Freeman, M.D., 525 Visger, Ecorse 48229

Raouf R. Hawash, M.D., 25701 Joy Road, Dearborn Heights 48127

Howard C. Hoffman, M.D., 612 First Street, Jackson 49203

Lawrence D. Hoffman, M.D., 20150 Audrey, Detroit 48235

Claudio M. Iacobelli, M.D., 22745 Kelly Road, East Detroit 48021

George A. Kling, M.D., Harper Hospital, Detroit 48201

Alfred M. Kreindler, M.D., 200 Elm Street, Birmingham 48008

Naşi D. Lessani, M.D., 36180 Five Mile Road, Livonia 48154

Melvin A. Lester, M.D., 26831 Woodward Ave., Huntington Woods 48070

William F. Malarney, M.D., 880 Woodward Avenue #106, Pontiac 48053

Edo V. Marcuz, M.D., 11255 Hall Road, Utica 48087

Milton Margoles, M.D., Newberry State Hospital, Newberry 49868

Sue Ann McCutcheon, M.D., Henry Ford Hospital, Detroit 48202

Moufid Mitri, M.D., VA Hospital, Dearborn 48121

Eliezer Monge-St. Laurent, M.D., 23607 Farmington Road, Farmington 48024

Rene Perez-Teran, M.D., 3033 Carpenter, Detroit 48212

Lawrence D. Pipe, M.D., Leila Hospital, Battle Creek 49014

Gordon R. Rady, M.D., 206 N. Heisterman St., Bad Axe 48413

Daleep S. Rao, M.D., 1207 N. Ballenger Highway, Flint 48504

Carl A. Rasimas, M.D., 1210 Kales Bldg., Detroit 48226

Richard C. Relken, M.D., 2920 Pine Grove, Port Huron 48060

Merle F. Rydesky, M.D., 16001 West Nine Mile Road, Southfield 48075

Enrique E. Signori, M.D., 29901 Ford Road, Garden City 48135

Willis H. Stephens, Jr., M.D., 602 N. Woodward Ave., Birmingham 48011

Jose S. Tandoc, M.D., 36200 Plymouth Road, Livonia 48150

Hratch Vartanian, M.D., 6246 Chase Road, Dearborn 48126

Rodolfo Yapchai, M.D., 1846 David Whitney Bldg., Detroit 48226

Thomas G. Schwaderer, M.D., 500 Cherry Street, S.E., Grand Rapids 49503

Miguel A. Casas, M.D., 9613 East Outer Drive, Detroit 48213

Rodger L. Johnson, M.D., 15001 West Eight Mile Road, Detroit 48235

Fred Averbuch, Maj, M.C., USAF Hospital APO, San Francisco 96323

Maximino J. Blanco, M.D., Pontiac State Hospital, Pontiac 48053

John S. Dunn, M.D., 368 Ridgemont, Grosse Pointe Farms 48236

Robert S. Levine, M.D., 900 Woodward Ave., Pontiac 48053

IN MEMORIAM

A. G. Armstrong, M.D., Detroit

A. Gordon Armstrong, M.D., Detroit physician for 43 years, died August 21 at the age of 71.

Doctor Armstrong was a member of staff at Hutzel Hospital and previously at Providence Hospital, Detroit.

Born in Ontario, Canada, he was graduated from the University of Toronto medical school in 1921. He served with the British Navy during World War I.

He was a 33rd Degree Mason and a member of the Detroit Athletic Club.

R. L. Fox, M.D., Traverse City

Richard L. Fox, M.D., Traverse City internist, died September 1, 1968. He was 36.

Doctor Fox was killed in an auto accident.

Doctor Fox received the B. S. degree from the University of Michigan and the M.D. degree from Northwestern University Medical School in 1958. Internship was at Henry Ford Hospital, Detroit, 1958-59. His residency was also done at Henry Ford Hospital, from 1959 through 1962. In 1962 he became a clinical cancer research fellow at the Detroit Institute of Cancer Research.

His practice was primarily in oncology. Hospital affiliations were with Munson Medical Center, Traverse City, and Mercy Hospital, Cadillac.

He was a member of Alpha Kappa Kappa.

L. B. Saraf, M.D., Detroit

Leo B. Saraf, M.D., Detroit surgeon, died June 28. He was 52.

Born in Sungurla in Asia Minor, Doctor Saraf received the A.B. degree from Wayne State University and the M.D. degree from Wayne State University School of Medicine in 1943. His internship was served at St. Mary's Hospital, now Detroit Memorial Hospital, and his residency at Detroit Receiving Hospital. He received formal postgraduate training in pathology at Wayne State University School of Medicine in 1943-44.

Doctor Saraf entered the private practice of general surgery in 1951. He was affiliated with St. Joseph Mercy, St. John, Receiving, Jennings and Detroit Memorial hospitals, Detroit.

He was a member of the American College of Surgeons.

Thomas Schrier, M.D., Comstock

Thomas Schrier, M.D., Comstock general practitioner, died September 6 at the age of 63.

He was affiliated with Borgess Hospital and Bronson Hospital in Kalamazoo.

Doctor Schrier received his premedical education at Kalamazoo College, Kalamazoo. He was graduated from the University of Michigan Medical School in 1931. During World War II, he served in the U. S. Army Medical Corps.

His medical fraternity was Theta Kappa Psi.

K. S. von Haitinger, M.D. Grosse Isle

Kalman S. von Haitinger, M.D., Grosse Isle psychiatrist, died in August. He was 61.

Doctor Haitinger was graduated in 1934 from the University of Louisville Medical School, Louisville, Kentucky. He received the A. B. degree from Tusculum College, Greeneville, Tennessee.

He began practice in Michigan in 1939. From 1942-46 he served in the U. S. Army Medical Corps.

He was a member of the American Psychiatric Association and of Alpha Kappa Kappa.

FOR YOUR PATIENTS:

Today's Health Guide is an up-to-date, 640-page, family health reference that should be in every home. The AMA's long awaited new book, Today's Health Guide, is the product of 200 of the world's most renowned authorities in medicine, science and allied fields.

The Guide discusses more than 2,000 illnesses, diseases and other medical subjects including diet and nutrition, child care, safety and first aid, sex education, mental health and when to seek professional medical attention. Over 300 striking illustrations and an eight-page full-color transparency of the human body vividly complement the text.

Today's Health Guide is the medical profession's answer to the need for an inexpensive yet authoritative and comprehensive home health guide.

Your patients may obtain one by sending a check or money order for $5.95 for each copy to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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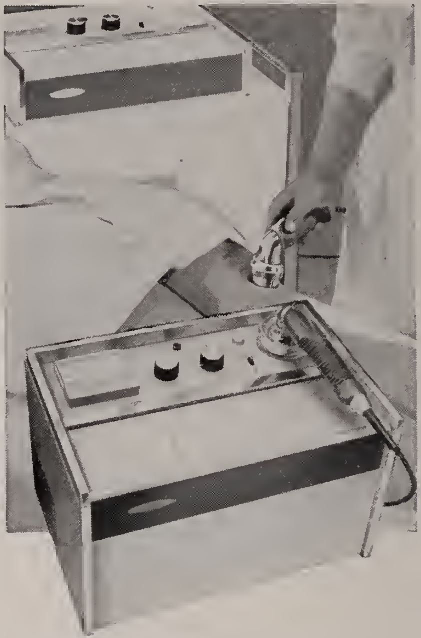

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New

Tegretol®
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trigeminal
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Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent
laboratory and clinical evaluations. Should this trend continue, the c
should be discontinued.
2. Liver function tests must be performed at regular intervals during
ment with this drug since liver damage may occur during therapy. Th
drug should be discontinued immediately in cases of aggravated live
dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and ton
etry, are recommended for patients being treated with this drug sinc
many phenothiazines and related drugs have been shown to cause e
changes.
4. Complete urinalysis and BUN should be done on patients treated
Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet,
nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocy
eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities
liver function tests, cholestatic and hepatocellular jaundice, urinary f
quency, acute urinary retention, oliguria with elevated blood pressure
albuminuria, glycosuria, elevated BUN, microscopic deposits in the u
impotence, disturbances of coordination, confusion, headache, fatig
blurred vision, transient diplopia and oculomotor disturbances, spee
disturbances, abnormal involuntary movements, peripheral neuritis a
paresthesias, depression with agitation, talkativeness, nystagmus, tin
nitus, paralysis and other symptoms of cerebral arterial insufficiency
pruritic and erythematous rashes, urticaria, Stevens-Johnson syndro
photosensitivity reactions, alterations in skin pigmentation, exfoliativ
dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, er
multiforme and nodosum, aggravation of disseminated lupus erythem
tosus, gastric distress, abdominal pain, diarrhea, constipation, anor
dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills,
adenopathy, lymphadenopathy, aching joints and muscles, leg cram
conjunctivitis, left ventricular failure, aggravation of hypertension, hy
tension, syncope and collapse, edema, aggravation of coronary arter
disease and congestive heart failure. (Whether these cardiovascular
are drug-related is not known. However, some of these complication
resulted in fatalities.) The necessity for discontinuing the drug shoul
dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with m
if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the
should be increased in one-half tablet (100 mg.) increments every 12
until freedom from pain is achieved. To relieve pain, between 200 m
1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patie
with a dose of 400 mg. to 800 mg. daily. Maintenance doses may ran
between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shoul
made to discontinue the drug or to reduce the dose to the minimum
effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottle
of 100 and 1000. (B)46-82
For complete details, please see Prescribing Information.

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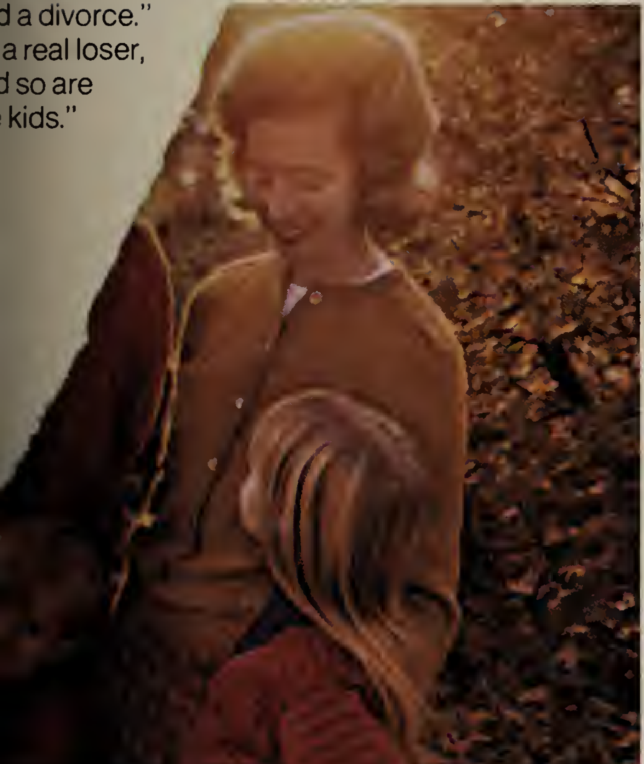


The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

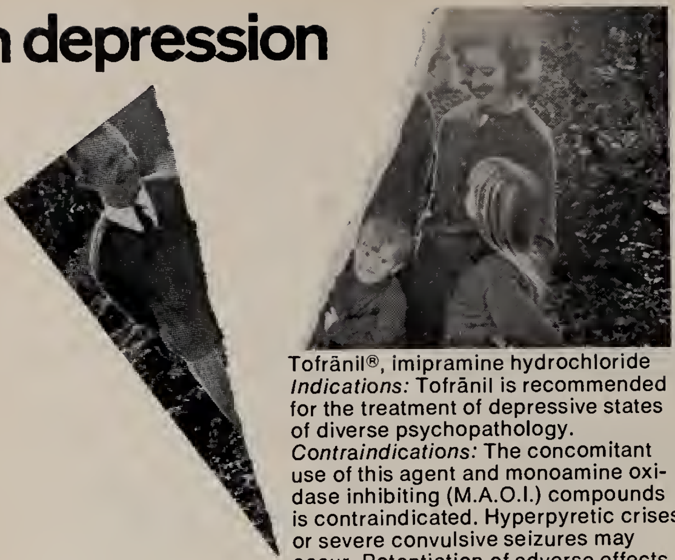
in depression **Tofrānil®** imipramine hydrochloride

Geigy

in depression

Tofrānil® Geigy

imipramine
hydrochloride



Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

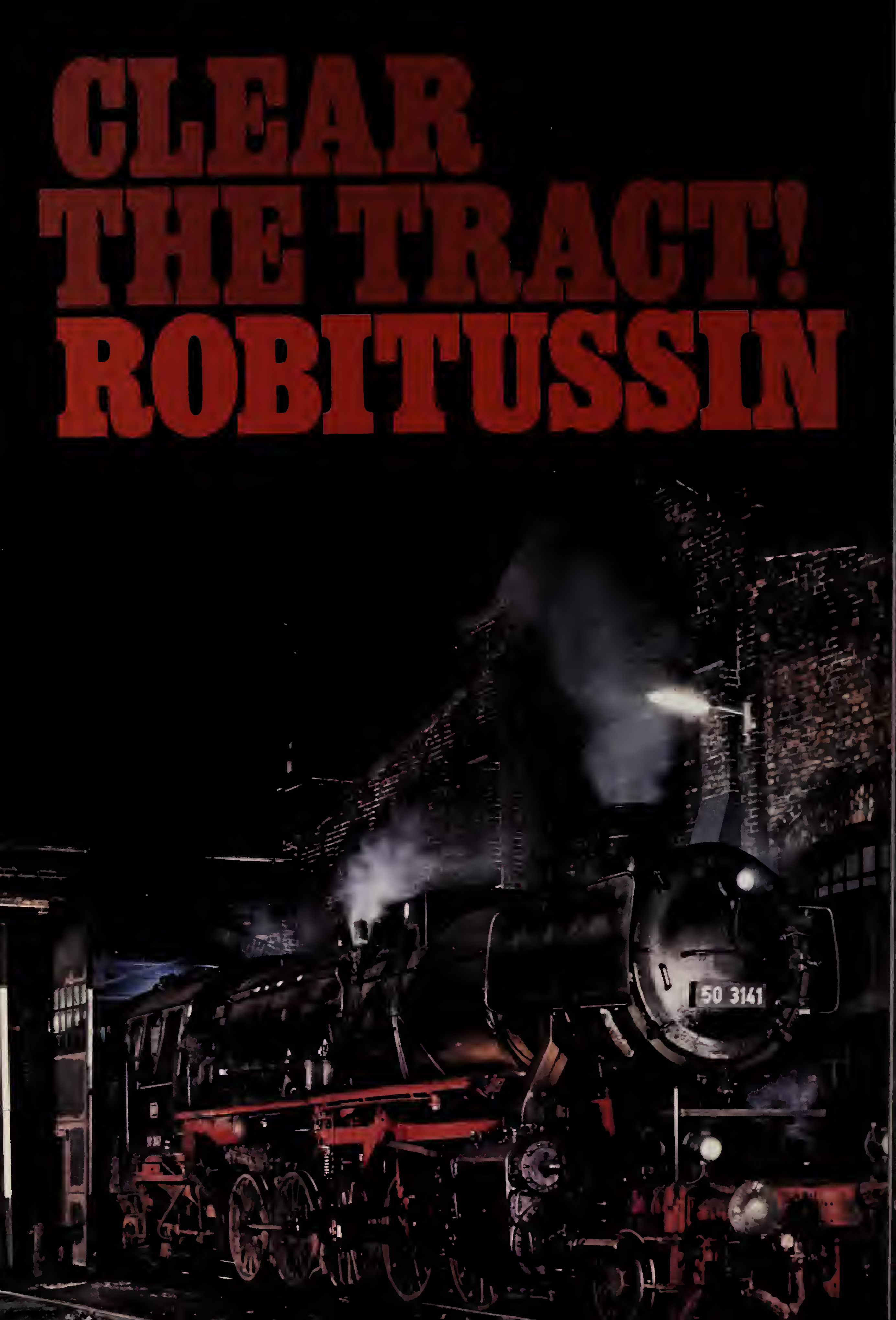
TO-6757

Donnagel®
For treatment of Diarrhea
A.H. ROBINS
SHAKE WELL
4 fl. oz

"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS


CLEAR
THE TRACT!
ROBITUSSIN
50 3141

THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.

Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Dextromethorphan hydrobromide .	15.0 mg.

Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Phenylephrine hydrochloride . . .	10.0 mg.

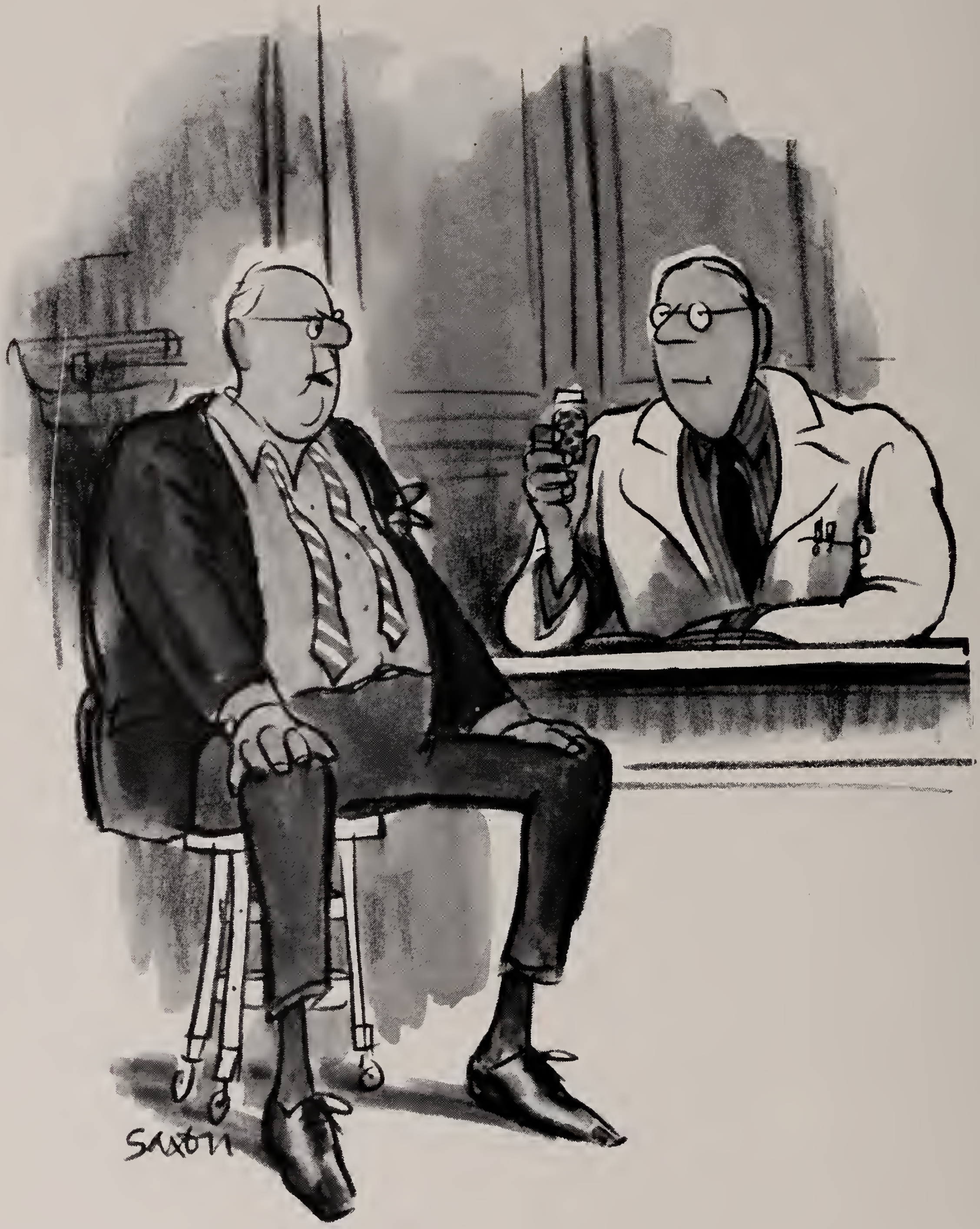
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Say you saw it in Michigan Medicine

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

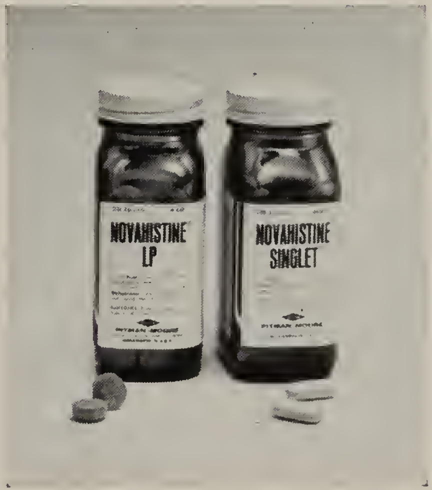
Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



An anorectic will help her lose weight– but can she keep it off? You need more than a pill (even ours) to do that!

That's why Abbott offers ou a pill plus a program.

ABBOTT

The Product

or smooth appetite ntrol plus mood evation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

5 mg.
10 mg.
15 mg.

or patients who can't ke plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

The Program

eight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.

the secret of controlling your weight

od Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

cture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444

To help you control your weight...

se see Brief Summary ext page.

Ask Your Abbott Man For Free Supplies

Say you saw it in Michigan Medicine

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

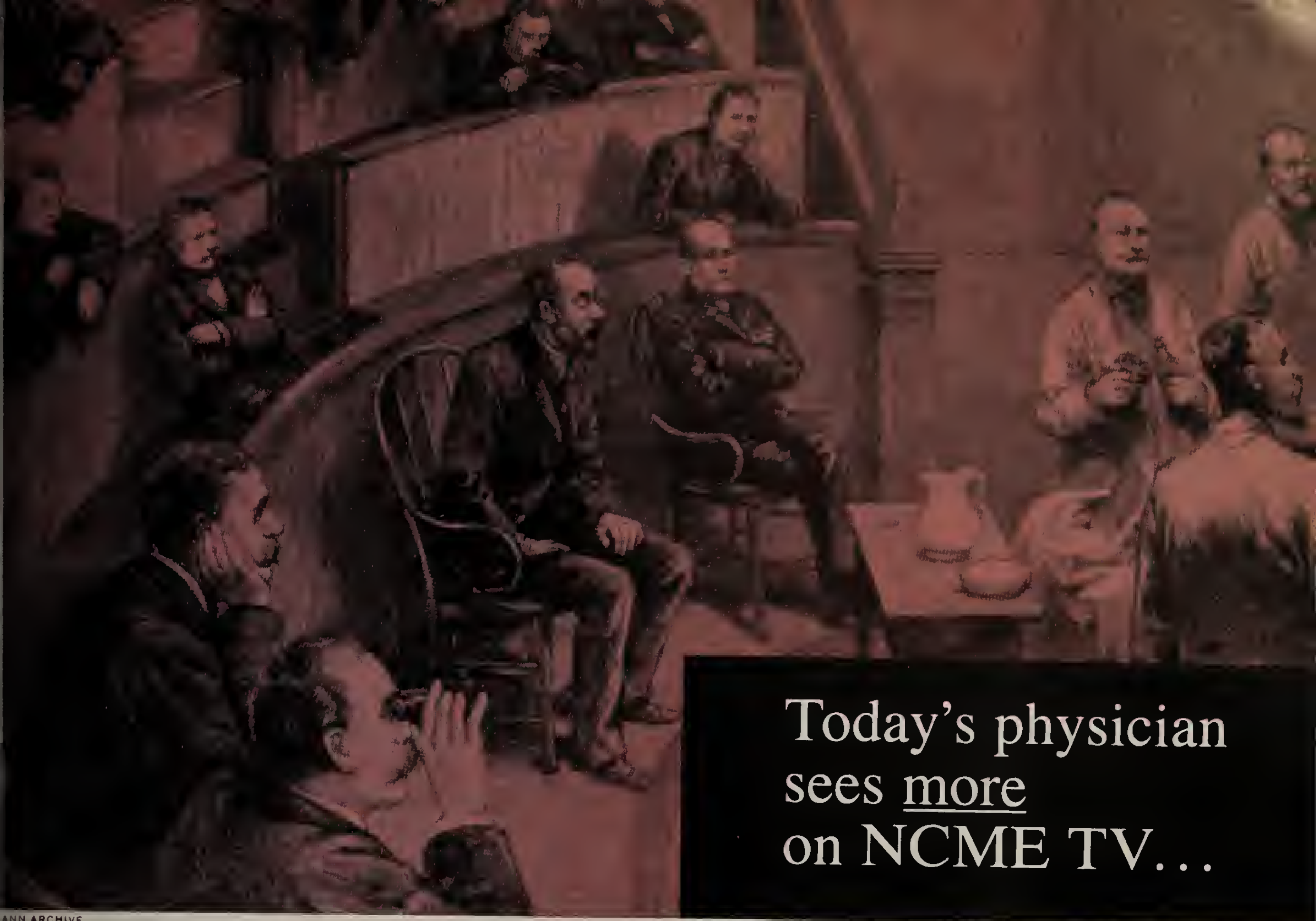
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*
anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064



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sees more
on NCME TV...

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Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to
NCME, 342 Madison Avenue
New York, N.Y. 10017

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

a stuffy nose
is no
laughing matter

Ornade® Trademark

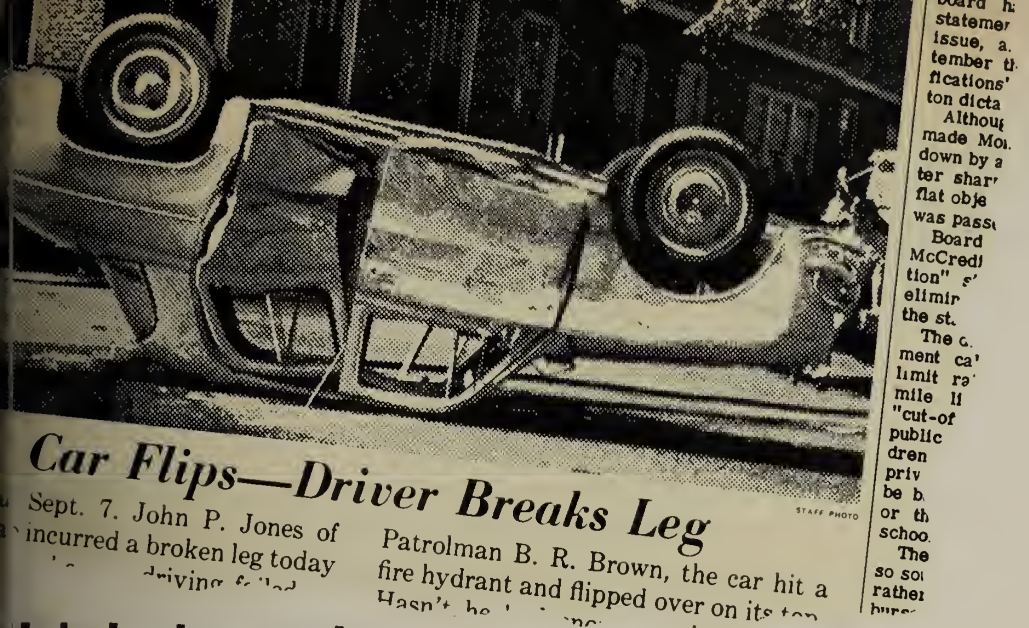
Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can
give him all-day
or all-night relief
of nasal congestion

SK&F Smith Kline & French, Laboratories



STAFF PHOTO

Car Flips—Driver Breaks Leg

Sept. 7. John P. Jones of
incurred a broken leg today

Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its top

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Ie's had enough excitement for one day.

'or the patient who has been through an accident, the worry and .nxiety following the experience may actually heighten the pereption of pain. This is why there's a classic 1/4 grain *sedative* ose of phenobarbital in Phenaphen with Codeine—*to take the ervous "edge" off,* so the rest of the formula can control the ain more effectively.

Phenaphen® with Codeine

henaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. Varning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; yoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. lo. 4). (Warning: may be habit forming).

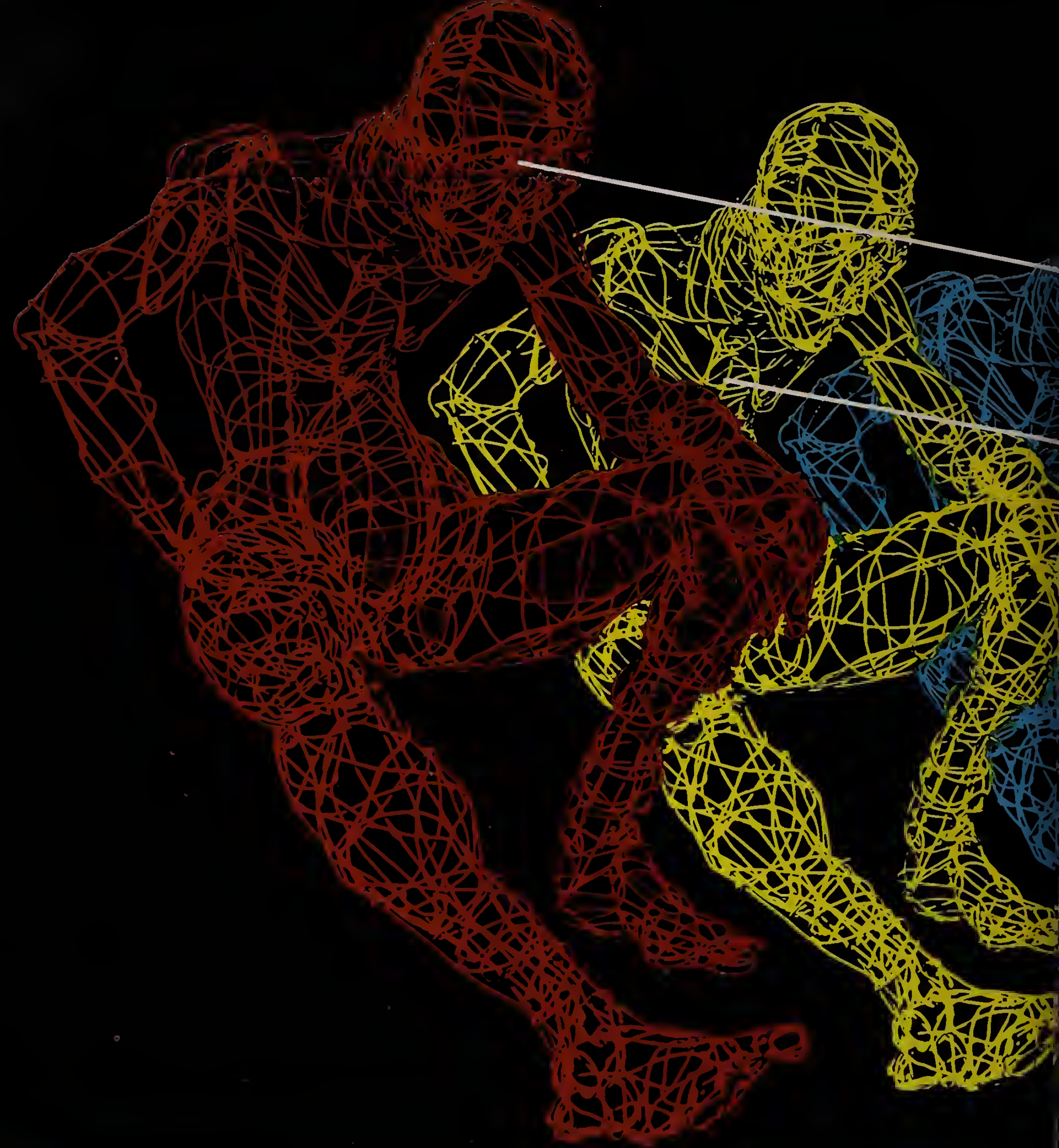
HE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires app
investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without a
vitamin B_{12} therapy may result in hematologic remission t
rological progression. Adequate doses of vitamin B_{12} (pa
or oral with potent intrinsic factor as in Trinsicon® [he
concentrate with intrinsic factor, Lilly]) usually prevent,
improve the neurological changes.

As with all preparations containing intrinsic factor, re
may develop in some cases of pernicious anemia to the p
tion of absorption of physiological doses of vitamin B_{12}.
ance occurs, parenteral therapy, or oral therapy with s
massive doses of vitamin B_{12}, may be necessary. No sin
men fits all cases, and the status of the patient obs
follow-up is the final criterion for adequacy of therapy.

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

ical and laboratory studies are considered essential and are ommended.

erse Reactions: In rare instances, iron in therapeutic doses duces gastro-intestinal reactions, such as diarrhea or consti- on. Reducing the dose and administering it with meals will imize these effects.

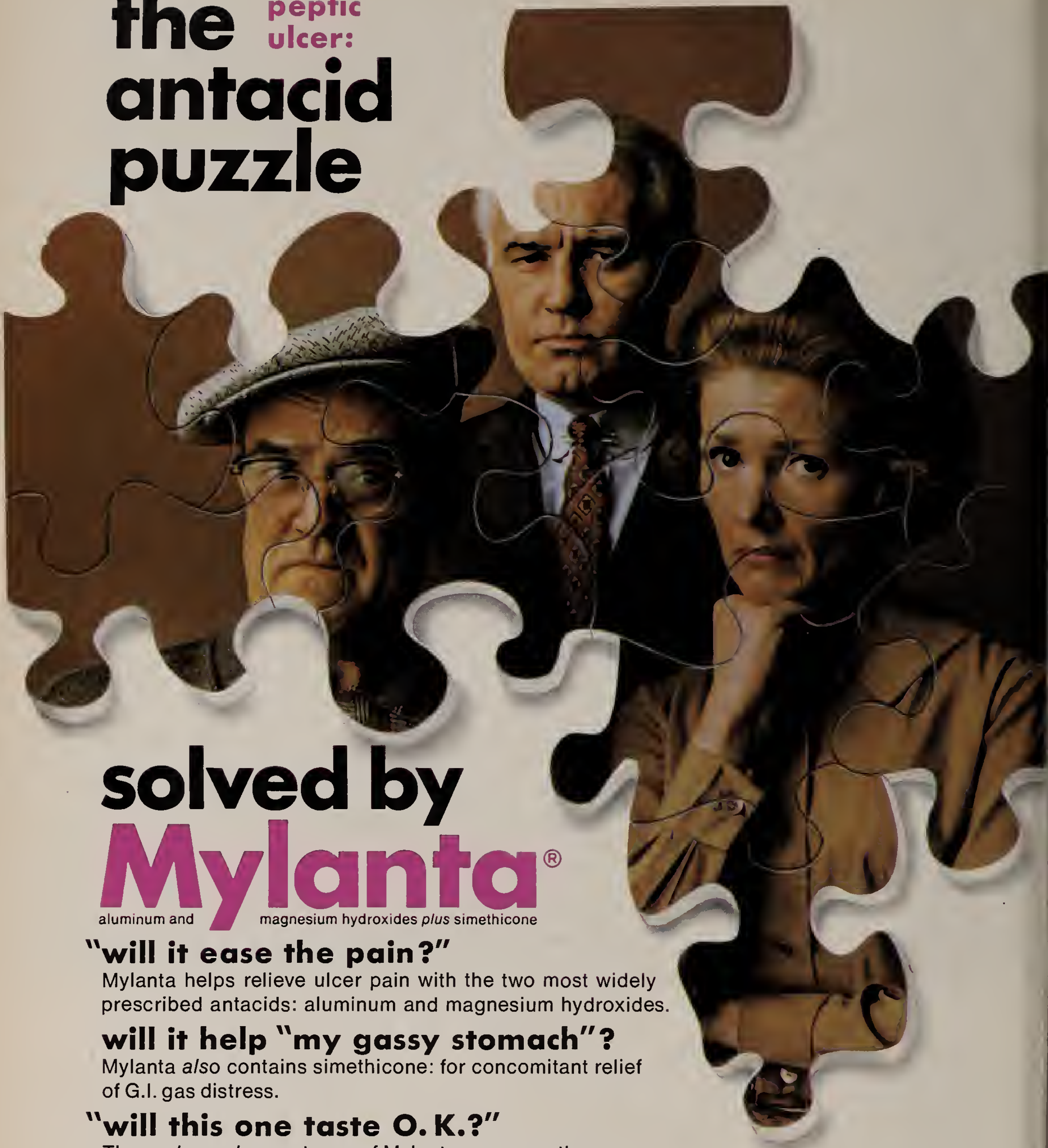
extremely rare instances, skin rash suggesting allergy has owed oral administration of liver-stomach material. Instances pparent allergic sensitization have also been reported after administration of folic acid.

age: One Pulvule twice a day. (Two Pulvules daily produce a dard response in the average uncomplicated case of perni- us anemia.)

Supplied: Pulvules Trinsicon® (hematinic concentrate with nsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information
available to physicians
upon request.
Eli Lilly and Company,
Indianapolis, Indiana 46206.
801668

Lilly



In peptic ulcer:

the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

...a checklist for updating your ECG

If you bought your present cardiograph several years ago, are you aware of the many improvements that have been designed into new ECG equipment for greater reliability and diagnostic accuracy?

- √ High frequency response for diagnostically accurate tracings
- √ Dependable, trouble-free service
- √ Adaptable for auxiliary use, such as phone transmission of ECG's, heart sound recording, recording Achilles tendon reflex to determine patient's thyroid dysfunction
- √ One-half, standard, and double standardization on all leads
- √ Fast switching from lead to lead — 25 or 50mm. recording speeds
- √ Ease of operation; light weight; attractive styling

Take another close look at your ECG. Does it give you these important advantages? Ask your Burdick dealer to demonstrate the EK 4 — it's an excellent investment for your practice or department.

THE BURDICK CORPORATION
MILTON, WISCONSIN 53563

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

Diarrhea
TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

When it's more than a bad cold

your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle
348-8

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

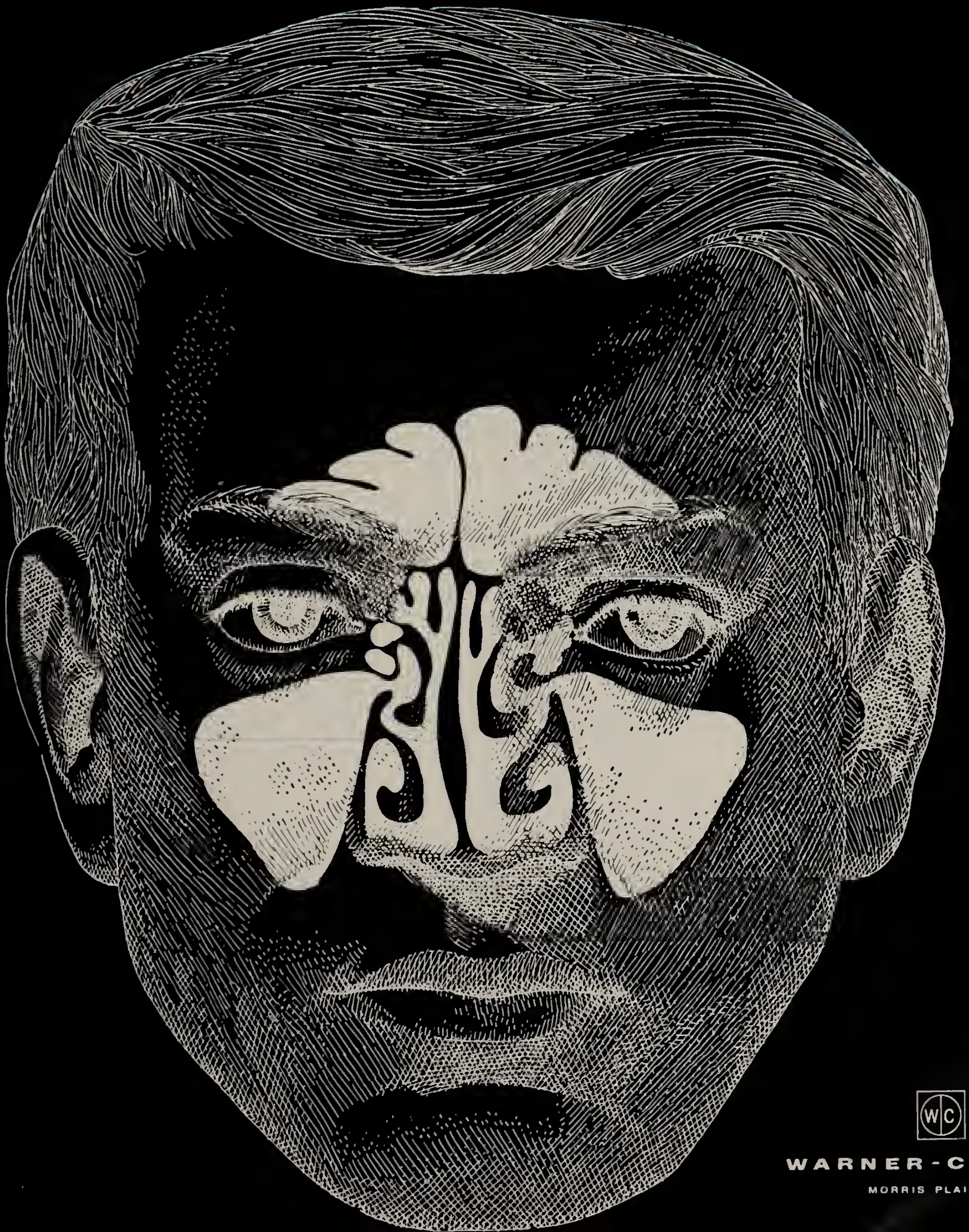
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4 h.



WARNER-CHILCOTT
MORRIS PLAINS, N J

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for the good taste of Soyalac

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Michigan State Medical Society

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

F. A. Nick, M.D., Ypsilanti,
has been selected team physician for the Olympic team for Iran. The Olympic Games in Mexico City will not be the first he has attended, as Doctor Nick was himself once a member of the Iranian team. A six-time national boxing champion of Iran, he competed as a bantamweight in the 1952 Games in Helsinki, Finland. Former ringside physician in the Florida Golden Gloves while serving his residency in Jacksonville, he now is a member of the Washtenaw County Medical Society's committee on athletics and of the American College of Sports Medicine.

Lynn D. Allen, M.D., Pontiac,
recently was reappointed by the Pontiac City Council to the Pontiac General Hospital Board of Directors. He was first appointed 10 years ago.

Donald H. Kaump, M.D., Ann Arbor,
has been promoted to director of the new Parke-Davis department of pathology and toxicology and will also serve as acting director of the department of experimental therapeutics. He is a special lecturer in pathology at the University of Michigan Medical School.

Edward F. Crippen, M.D., Detroit,
formerly of Mancelona and more recently Deputy Commissioner of Health for the City of Detroit, has begun his new duties as Nevada State Health Officer in Carson City.

Arthur C. Curtis, M.D., Ann Arbor,
will address the annual leadership conference of the American Social Health Association in New York City Oct. 27-28 when the voluntary agency meets to consider "Venereal Disease Research Priorities: Biologic, Behavioral and Control." Doctor Curtis, professor of dermatology, University of Michigan, will speak about plans and priorities in control measures of the nongovernmental organization.

William B. Weil, Jr., M.D., East Lansing,
chairman of MSU's new Department of Human Development, has been named president-elect of the Society for Pediatric Research. He has been secretary of the society since 1962.

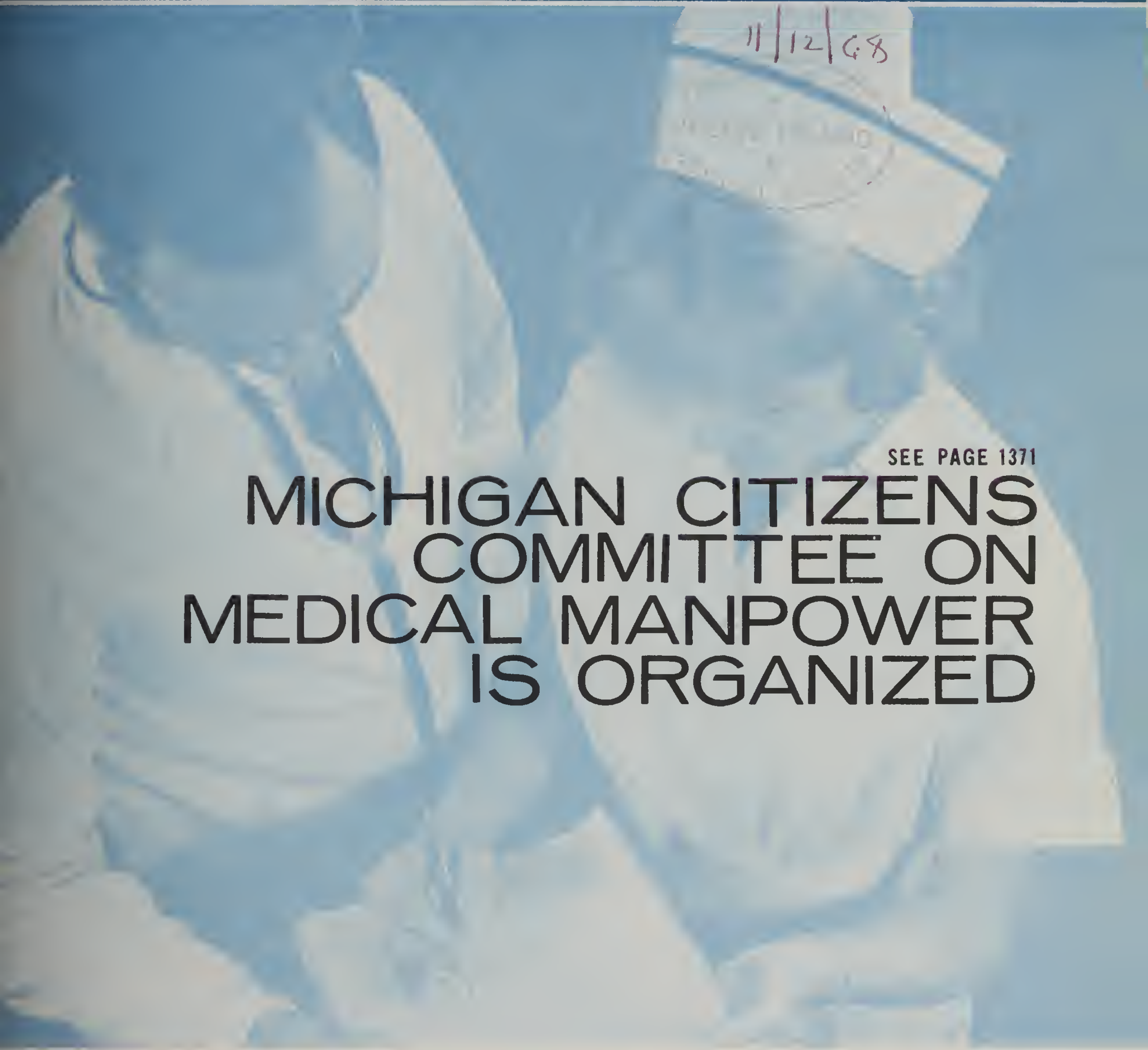
Vernon V. Bass, M.D., Saginaw,
Vice-Speaker of the MSMS House of Delegates, spoke to the Ottawa County Medical Society October 4 during a program exploring various possible projects and activities for county medical societies.

John J. Hanlon, M.D., Detroit,
began new duties in September as the Assistant Surgeon General in the Public Health Service in Washington. He formerly had been Commissioner of Health of the City of Detroit and head of the WSU Medical School Department of Community Medicine.

Shirley Austin, M.D., Detroit,
spoke at the MSMS pre-convention news luncheon in Detroit September 18. She discussed "Relief of Pain" for the press, radio and television reporters.

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

MICHIGAN MEDICINE



11/12/68

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MICHIGAN CITIZENS COMMITTEE ON MEDICAL MANPOWER IS ORGANIZED

ICHIGAN STATE MEDICAL SOCIETY JOURNAL VOLUME 67, NUMBER 21 NOVEMBER 1968

AMONG THE IMPORTANT ARTICLES:

Warthin's Tumor Revisited
And Other Original Articles
Review of Some New Michigan Laws
Photos and Articles from Annual Session
Several Socio-Economic Articles

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COVER

The cover focuses attention on the efforts of the new Michigan Citizens Committee on Medical Manpower, which was called together October 16 by MSMS. See the article on 1371.

SPECIAL FEATURE

Special articles and photographs from the 1968 Annual Session are featured in this issue. See Pages 1357, 1358, 1359, 1360, 1361, the center blue pages, and other pages, too. Some photos appeared in the October News Extra and others will appear in the December journal.

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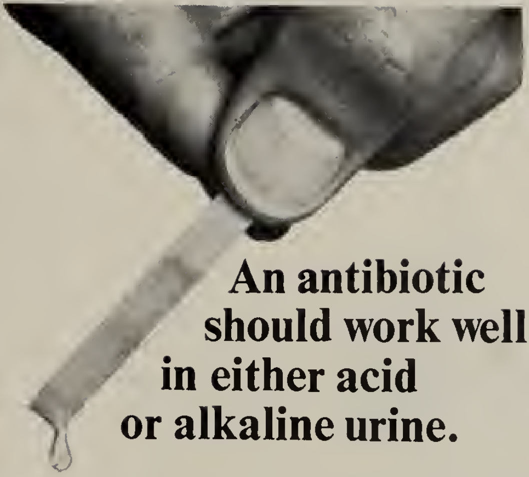

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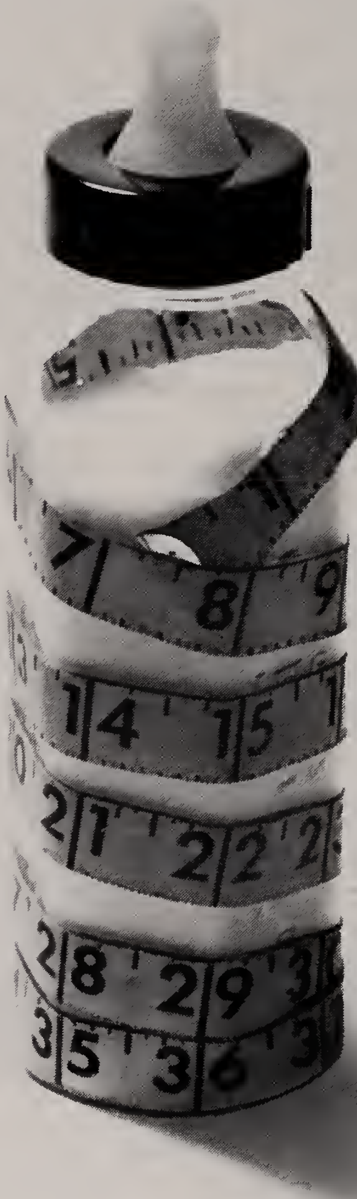

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*Lowe, Charles U., M. D., Mosovich, Luis L., M. D., and Pessin, Vivian, Ph. D.; Effects of Protein Level and Type of Heat Treatment of Milk Formulas on Growth and Maturation of Infants, J. Pediatrics 64:666-682 (May) 1964.

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BY JAMES J. LIGHTBODY, M.D.

MSMS PRESIDENT'S MESSAGE

Consider These Points . . .

(Editor's Note: At our suggestion, Doctor Lightbody has consented to using portions of his address to the 1968 House of Delegates for his President's Page in this issue.)

Let us hope that in the year ahead, that we, as physicians, will continue to give the best medical care possible to all segments of our population. The changes we are seeing in medical practice and hospitals are medical expressions of the same changes that are occurring in education, industry, government and in the entire social landscape.

The scientific progress of medicine, rising per diem costs in hospitals, and the mounting shortages of personnel to deliver high quality medical care are causing far-reaching changes in the whole spectrum of health service. The benefits of latest medical techniques can be delivered only through the inter-action of many specialists, and that in itself inevitably introduces an element of impersonality in the way the patient is treated.

It is fashionable in some quarters to level a constant barrage of criticism at physicians. Doctors are blamed for all the ills of society from juvenile delinquency to air pollution. This is both unjust, unfair and not based on the facts. The so-called "image" of the physician is still considered to be the highest and best of the professional and nonprofessional groups.

We should continue to support the activities of the state and local health departments as their activities many times overlap with our own health programs concerned with direct patient care.

One of the matters of great current interest to the Michigan State Medical Society is its relationship with the Negro physicians in this state, and this, I believe, is a major challenge and should be squarely met with the endorsement of a coordinated, bilateral program to improve our communications with the Detroit Medical Society and National Medical Association. Negroes constitute 11.4% of the nation's population, but have only 2.2% of the nation's physicians. According to a recent report released by the American Association of American Colleges, approximately 300 Negro students are expected to enter United States medical schools this fall. This represents a 50% increase over the situation five years ago.

The majority of Negro physicians have felt that the American Medical Association did not have a realistic motivated program to assure better care for Negro patients and did not fully comprehend the professional load that the Negro physicians of this country were carrying in attempting to take care of the great number of Negro patients. The difficulties that some Negro physicians have had in gaining hospital staff appointments is well-documented, but this is also true of some white physicians.

Specifically, I would suggest that state and county medical societies re-evaluate their interests in programs affecting the medical care of both the black and white poorer segments of our urban areas particularly, and make every effort to improve the professional relations of Negro physicians in all areas of health activities. I feel, however, that Negro physicians themselves should make a greater effort to participate in county and state medical societies' programs and activities so that we can eventually eliminate any racial inequities that may now exist.

Another matter of major concern is the care of the older people who are chronically ill. We must see the older patient as one of the great challenges in medicine rather than a candidate for custodial care First class care for older people will lead to improved, preventive measures for younger ones. This frequently involves participation of county, state and federal programs, but this is going to be an expanding area of activity in the years ahead and the medical profession must concern itself in cooperating with and giving direction to public agencies.

The transition of our medical care system simply mirrors the transition of our whole society. Let us hope that this transition will bring some degree of stability—and perhaps, some degree of tranquility.

The new direction in which American medicine is going is not necessarily bad because it is different. William Osler wisely said: "The philosophies of one age become the absurdities of the next, and the foolishness of yesterday has become the wisdom of tomorrow."

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Tandearil®

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis:
Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

anticostive* hematinic

60
Lederle
PERITINIC
Hematinic with Vitamins and Fecal Softener
TABLETS

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Easy on the Budget...
Easy on the Mother

Tablets & Elixir

For Iron Deficiency Anemia

FAMOUS
Fergon®
brand of FERROUS GLUCONATE

BREON
BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit
four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

Dilantin®
diphenylhydantoin)

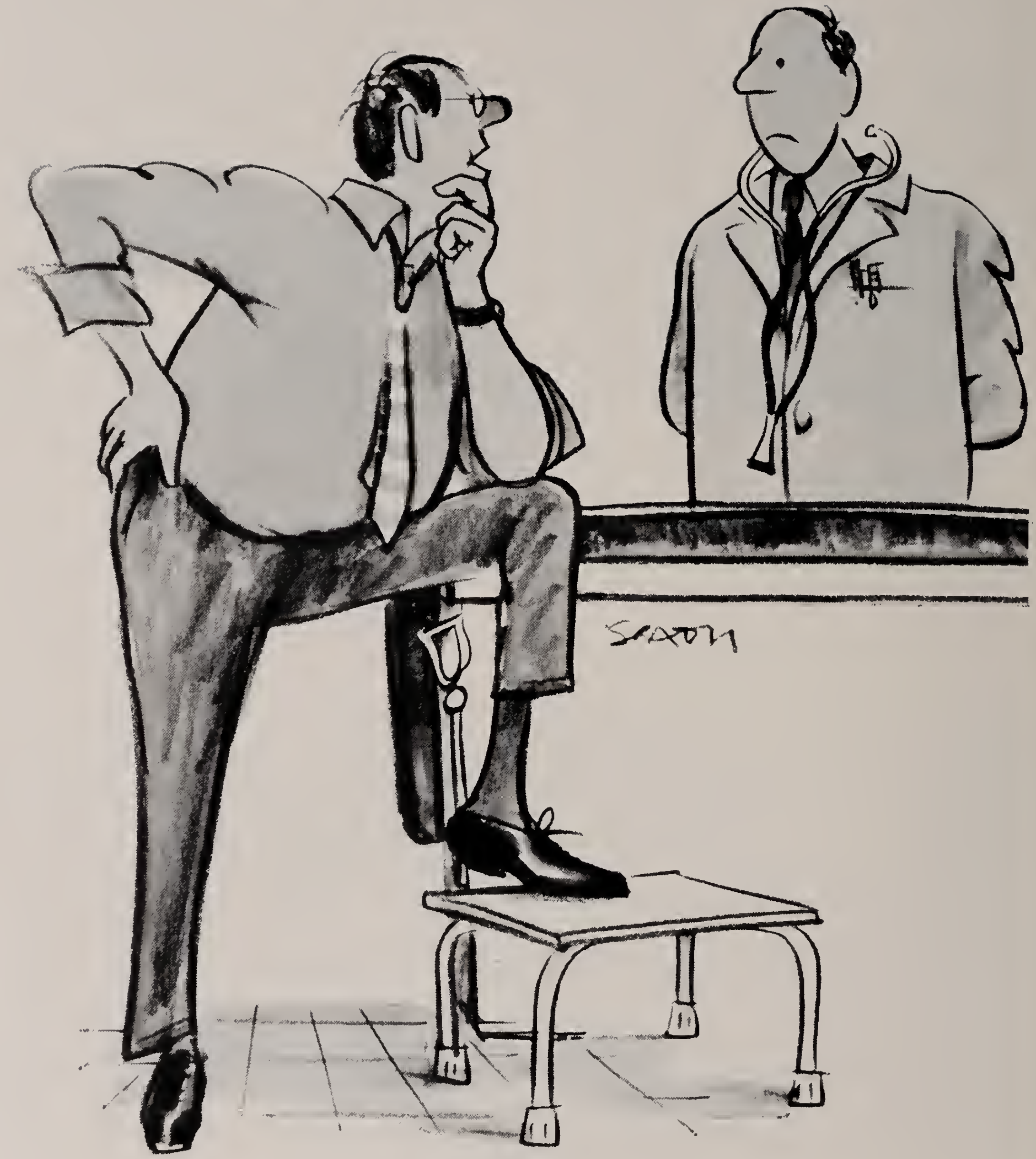
RKE-DAVIS

n untold thousands of pileptic patients... ilantin has been, and ontinues to be, the edrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

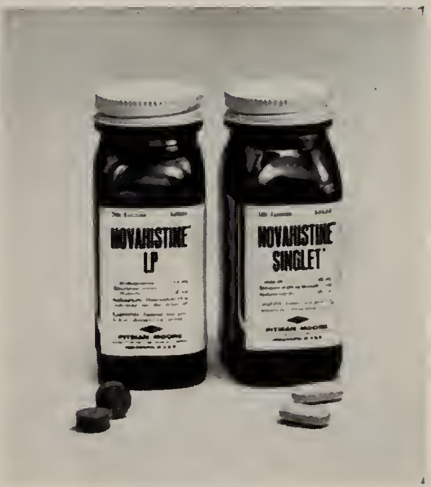
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth®

reathing's
snap again,"
he said
gingerly.
(COMPLIMENTS OF
DIMETAPP)

clear up that miserable stuffed-up ng with Dimetapp. Each hard-work- Extentab brings welcome relief from tuffiness, drip and congestion of upper iratory conditions for up to 10-12 s. Yet, patients seldom experience siness or overstimulation. The key to ess is the Dimetapp formula: Dime- (brompheniramine maleate)—along phenylephrine and phenylpropanola- , two time-tested decongestants. They ne job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. *Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Dosage:* 1 Extentab morning and evening. *Supplied:* Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

sinusitis, colds, U.R.I.

imetapp® Extentabs®

ane® [brompheniramine maleate], 12 mg.;
lephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

to 10-12 hours clear
eathing on one tablet

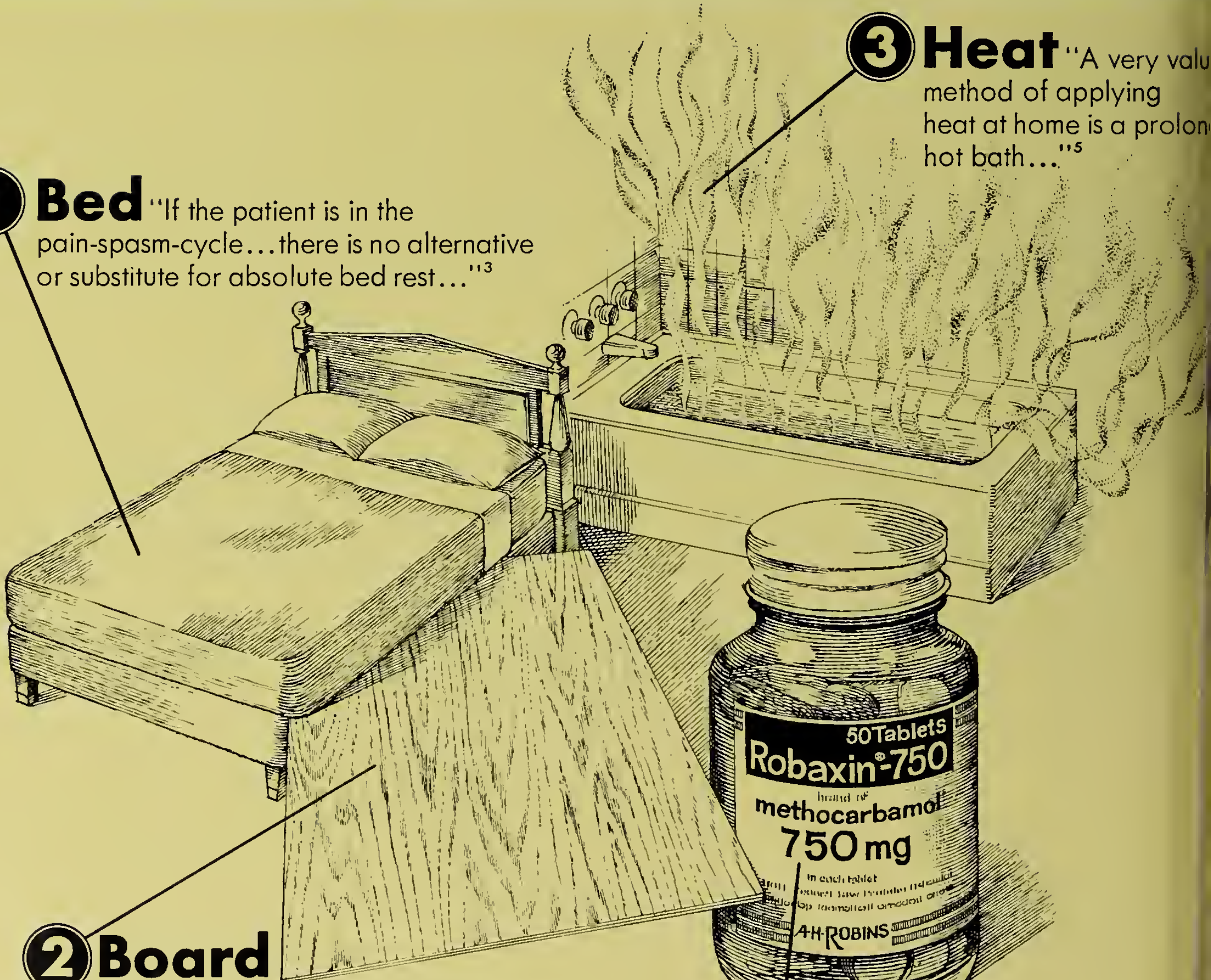
LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

③ Heat "A very valu method of applying heat at home is a prolon hot bath..."[5]

① Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]



② Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

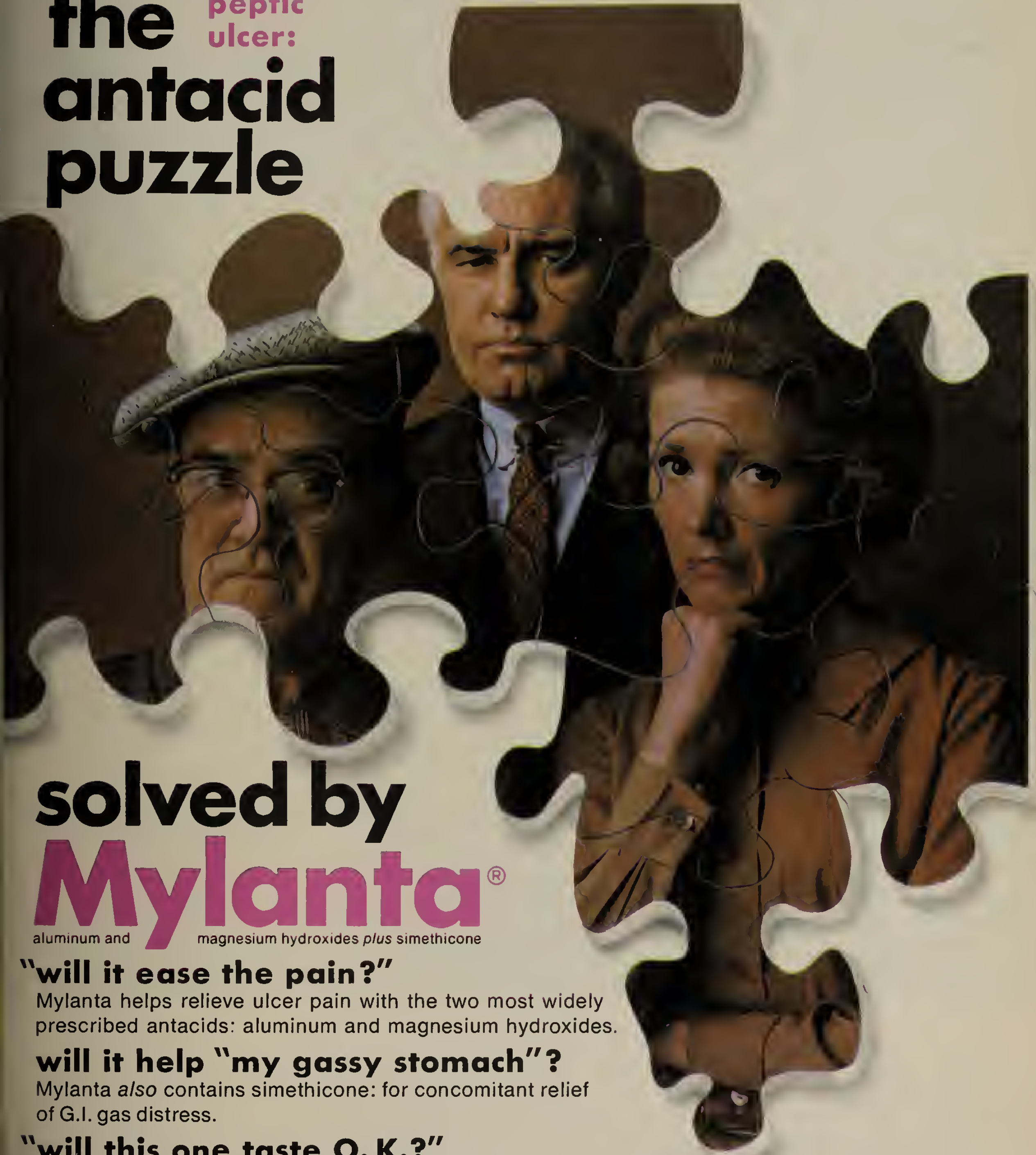
④ Robaxin®-750 (methocarbamol, 750 mg. caps shaped tablets) A well-tolerate skeletal muscle relaxant, metho bamol helps relieve spasm "...without interfering with nor tone and movement."[7] And the is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) **References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A-H-ROBINS A. H. ROBINS COMPA
RICHMOND, VIRGINI

In peptic ulcer:

the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

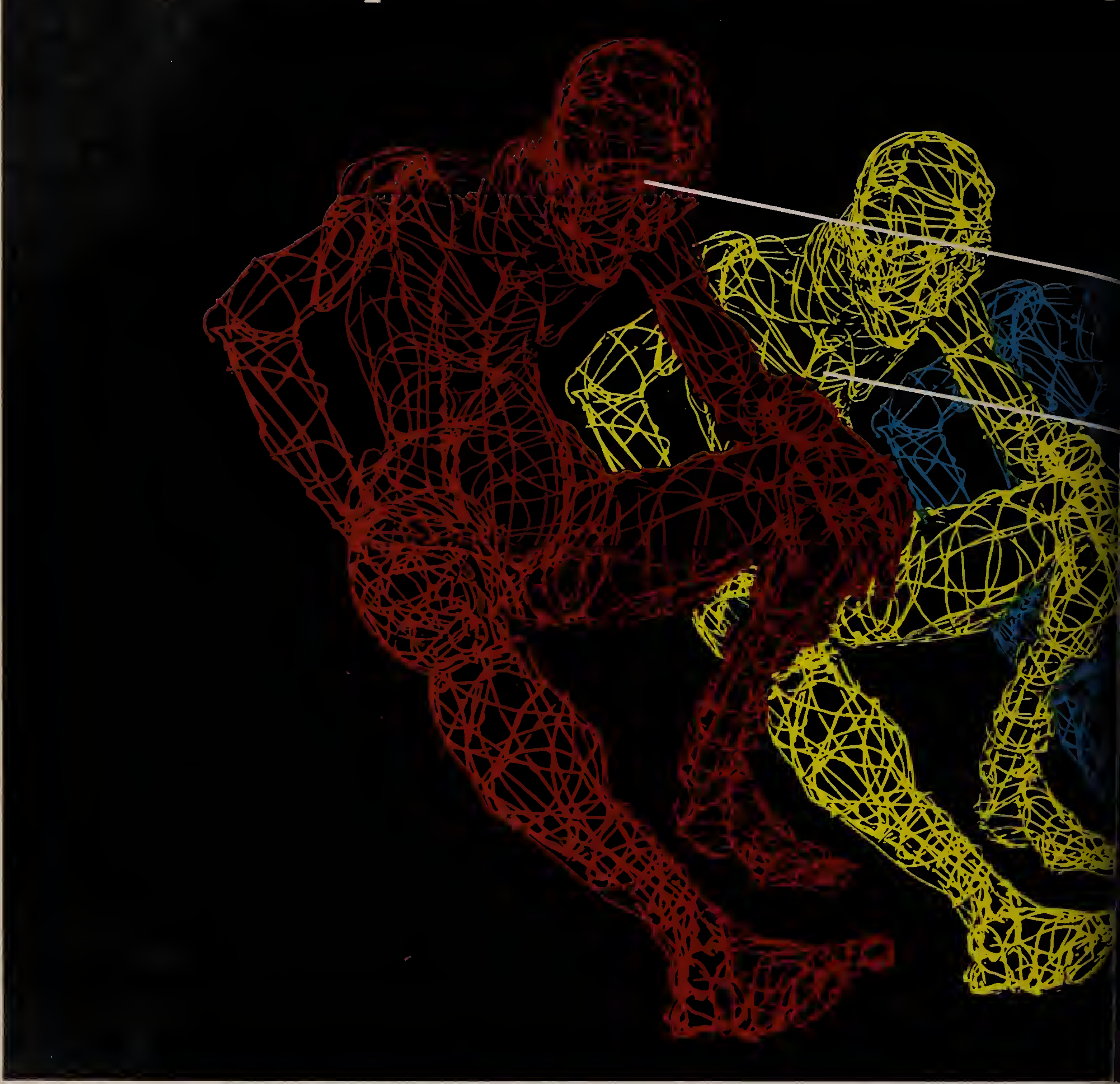
"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematini



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

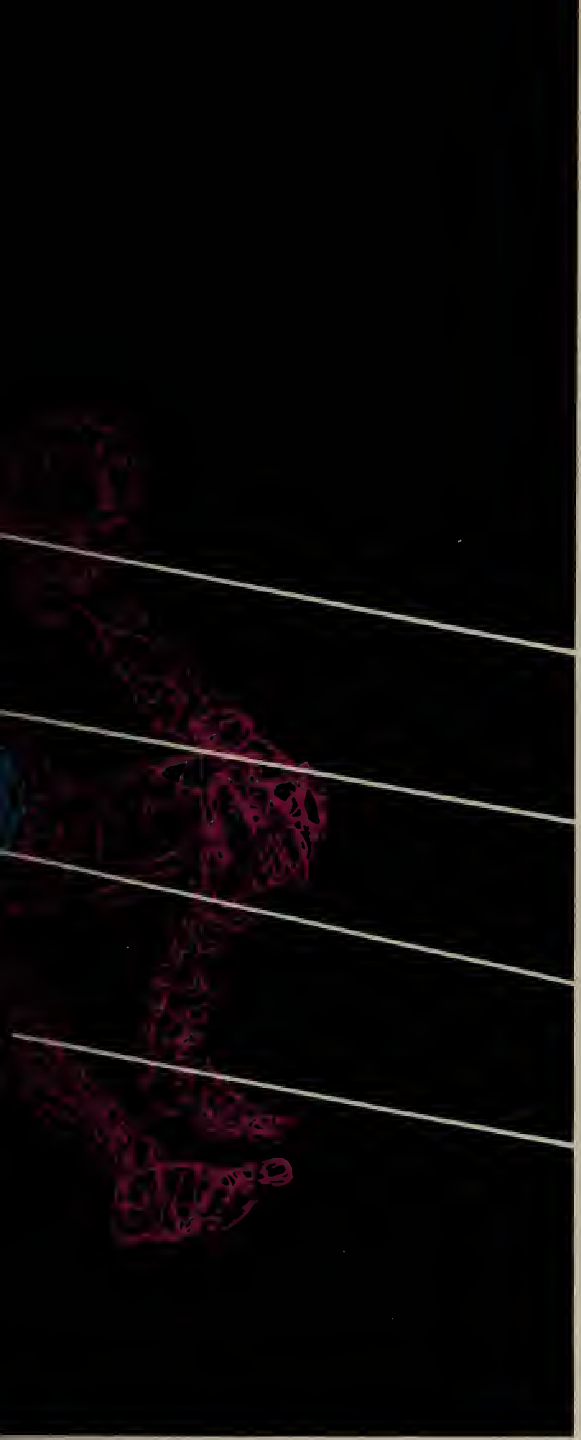
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appr
investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without ad
vitamin B_{12} therapy may result in hematologic remission b
rological progression. Adequate doses of vitamin B_{12} (pare
or oral with potent intrinsic factor as in Trinsicon® [her
concentrate with intrinsic factor, Lilly]) usually prevent,
improve the neurological changes.

As with all preparations containing intrinsic factor, res
may develop in some cases of pernicious anemia to the pc
tion of absorption of physiological doses of vitamin B_{12}. If
ance occurs, parenteral therapy, or oral therapy with sc
massive doses of vitamin B_{12}, may be necessary. No sing
men fits all cases, and the status of the patient obse
follow-up is the final criterion for adequacy of therapy. F



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

nd laboratory studies are considered essential and are
nded.

Reactions: In rare instances, iron in therapeutic doses
gastro-intestinal reactions, such as diarrhea or consti-
educing the dose and administering it with meals will
these effects.

emely rare instances, skin rash suggesting allergy has
oral administration of liver-stomach material. Instances
nt allergic sensitization have also been reported after
nistration of folic acid.

One Pulvule twice a day. (Two Pulvules daily produce a
response in the average uncomplicated case of perni-
mia.)

plied: Pulvules Trinsicon® (hematinic concentrate with
actor, Lilly), in bottles of 60 and 500. [032568]

Additional information
available to physicians
upon request.
Eli Lilly and Company,
Indianapolis, Indiana 46206.
801668

Lilly

"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

Winthrop Laboratories, New York, N.Y. 10016

e-popular treatment for back pains
have the seventh son of a seventh son
or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

dache, a sovereign remedy was
a snakeskin round one's head.

A realistic approach to pain relief

mpirin'®

npound with Codeine
sphate gr. 1/2 No. 3

blet contains:
Phosphate gr. 1/2 (Warning—
habit forming), Phenacetin gr. 2 1/2,
gr. 3 1/2, Caffeine gr. 1/2.

ps the promise
ain relief

.' narcotic products are
and as such are available on oral
n, where State law permits.

RROUGHS WELLCOME & CO. (U.S.A.) INC.
kahoe, N.Y.

Muscle in Spas

and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

HOD
CARMEL
כשר
DELICATESSEN
CATERING

A lit

Just one 50 or
tablet in the m
can work a lon
diuretic day in
and hypertens

HY-6060

ygroton® can work a long day too

thalidone

ecause of its prolonged
vhich usually provides
diuretic activity
out the day. And
ay dosage means few
o take and few tablets
r in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

ygroton

thalidone in edema and hypertension

Geigy

HOD
CARMEL
CATERING

in edema and hypertension

A little Hygroton® can work a long da

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.
Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated v
chlorthalidone is combined with
biturates, narcotics or alcohol, a
anemia, leukopenia, thrombocyt
penia, agranulocytosis, impoten
dysuria, transient myopia, skin r
urticaria, purpura, necrotizing a
acute gout, and pancreatitis whe
epigastric pain or unexplained G
symptoms develop after prolong
administration. Other reactions
ported with this class of compou
include: jaundice, xanthopsia, p
thesia, and photosensitization.
Average Dosage: 50 or 100 mg.
breakfast daily or 100 mg. every
day.
Availability: White, single-score
lets of 100 mg. and aqua tablets
mg., in bottles of 100 and 1000.
(B)46-230-E

For full details, please see the complete prescribing informati

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Is it depression?

He says "It's my stomach..."

...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt
strongly suggest
an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

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Warthin's Tumor Revisited

ABSTRACT: Warthin's tumor is a tubulo-papillary-cystic oncocytoma arising from parotid duct cells enclaved in lymph nodes external to or within the parotid gland. It is an asymptomatic completely benign tumor seen in middle-aged Caucasian males, representing from six to 10% of all parotid tumors. The tumor is readily removed surgically. Descriptive pathological features are reviewed.

BY MERRILL A. COHEN, M.D.
JOHN G. BATSAKIS, M.D.
BOTH OF ANN ARBOR

It is almost 40 years since A. S. Warthin[1] described and presented for the first time in the American literature the tumor, papillary cystadenoma lymphomatosum. Since then, and in numerous papers, the lesion, either by form of tribute or through facility, has been commonly called Warthin's tumor.

Many of the ensuing reports were by pathologists who, perhaps piqued by the unusual association of lymphoid and epithelial tissue displayed by the tumor, presented a variety of histogenetic theories. Two studies stand out amongst the several hundred recorded in the literature: Thompson and Bryant's[2] elucidation of the pathogenesis of the lesion and the review of the clinical features by Chaudhry and Gorlin.[3]

The present report, 40, 20 and 10 years after the three aforementioned publications, is a contemporary compendium of the clinical, pathological, experimental and nosological features of this unique tumor.

Histogenesis and Nosology

Early reports included many hypotheses for the development of the Warthin tumor.[2-4] The currently accepted theory is an origin from heterotopic salivary gland tissue within lymph nodes external to or within the parotid gland.

Thompson and Bryant[2] studied the embryonic development of the salivary glands and found that whereas the submaxillary and sublingual glands develop as compact entities, the parotid gland develops in a loose arrangement containing aggregates of lymphoid tissue, and encapsulation occurs late in ontogeny. Thus, lymph nodes become enclosed with the parotid gland, and salivary ducts and acini become included in these nodes, as well as in nodes outside the definitive gland which were excluded by the formation of the capsule. It is from these ductal epithelial elements, incorporated in lymphoid tissue outside and within the parotid capsule, that the tumors arise. The finding of ductal inclusions in lymph nodes in or near the parotid, the occasional multicentricity of Warthin's tumor in several apparently uninvolved lymph nodes, and the relatively undisturbed lymph nodal architecture seen about tumors removed at an early stage of their formation are features supporting this thesis (Figures 1-4) .[5, 6]

The cause of the oxyphilic alteration in the epithelial elements is not known.

Whether or not the oxyphilic adenoma, the so-called oncocytoma, is a variant is also not known. This tumor, also composed of oxyphilic, finely granular epithelial cells may have a solid or medullary pattern, or be tubulo-papillary-cystic. It **does not** have a lymphoid component. Its origin is from salivary ductal epithelium, and the ultrastructure of the epithelium is identical to the cells of the Warthin's tumor.[7] In the Warthin's tumors studied by Thompson and Bryant,[2] masses of polyhedral oxyphilic epithelial cells were noted, similar in pattern to the medullary oncocytoma, and so for classification purposes, Warthin's tumor may be regarded as an oncocytoma of tubulo-papillary-cystic type arising from parotid duct cells enclaved in lymph nodes.[5]

Clinical Features

Although Warthin's tumor has been reported as occurring in a wide age span (2½[8] - 92 years[9]), 82% are found in patients between 41 and 70 years of age (avg. = 55.6 years[3]). There is a decided (5 to 1) male predominance.[3] Only one case has been reported in a Negro.

The tumor is asymptomatic; only 10% of patients present with complaints other than a symptomless mass, those complaints being pain, pressure sensations or rapid increase in size of the tumor. Facial nerve weakness has been reported only once. The lack of discomfort accounts for the

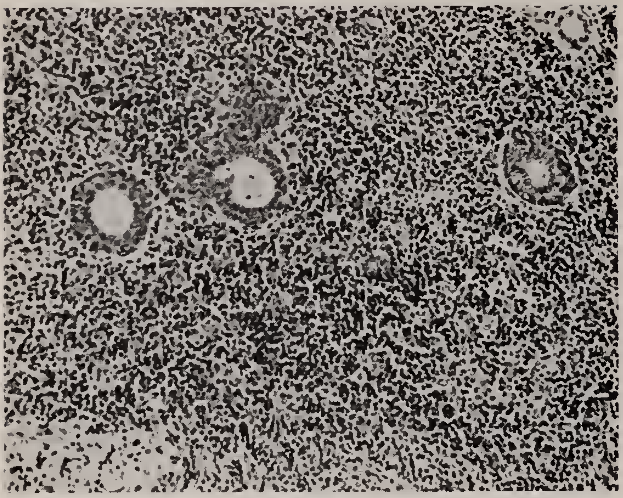

FIGURE 1

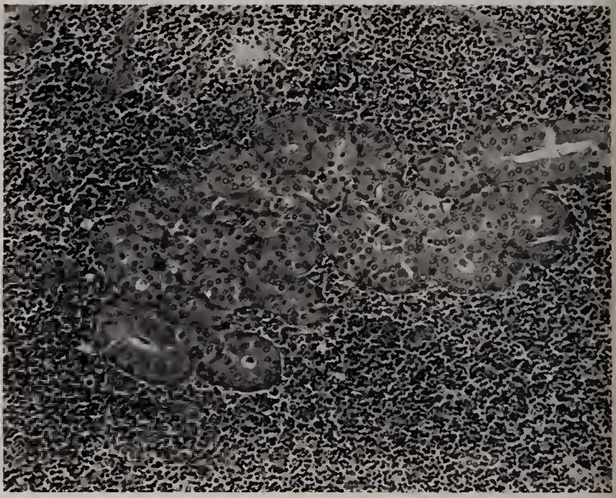

FIGURE 3

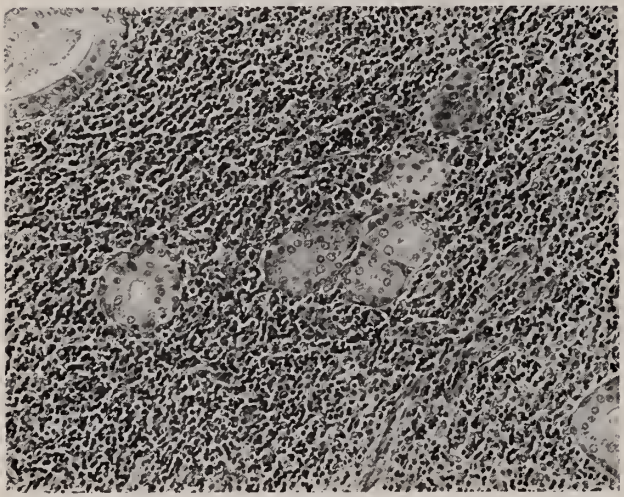

FIGURE 2

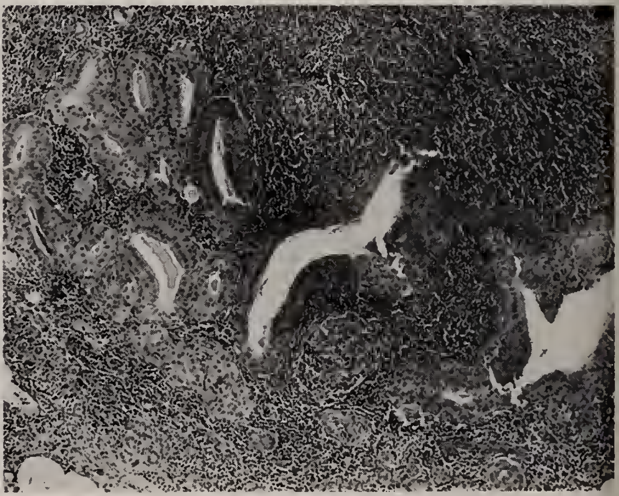

FIGURE 4

Figures 1 through 4 are representative of the ductal changes occurring in the progressive genesis of a Warthin's tumor. Figure I is the earliest stage of development with ductal elements enclaved in lymphoid tissue. This is followed by progressive hyperplasia (Figures 2-3) and then by dilation and intra-cystic papillation of the included ducts. Continued development of the lesion leads to the appearance illustrated in Figure 5.

relatively long duration before diagnosis. The average duration is three years and reports give a range of two weeks to 30 years.[3]

Despite reports of the tumor occurring in sites other than the parotid gland or its environs, Warthin's tumor is best considered as a lesion of the parotid gland, where it represents 6%[3] to 10%[10] of all parotid gland tumors; second in frequency of benign tumors only to the mixed tumors. It occurs most often in the lower pole of the gland, next to the angle of the mandible.[3] Because of the pathogenetic relationship described above, the tumor may arise in lymph nodes superficial or medial to the parotid gland. In 29 instances, the tumors were bilateral.[11]

Baum and Perzik[11] and Martin and Ehrlich[12] pointing out the intimate relationship of the tail of the parotid gland with the submaxillary gland, doubt the validity of the latter being reported as a primary site. A few unquestionably Warthin tumors have been noted in the lower lip[13, 14] and the palate[15] but doubts exist over the credibility of reported tumors in the oropharynx, hypopharynx, posterior nasal space, larynx, and thyroid gland.

The tumor is well-defined, soft or fluctuant or, if deep within the gland, firm to palpation. The average size is given as 3.6 cm. with a range of 1 to 8.5 cm. at the time of surgical removal.[3]

The preliminary clinical impression is mixed tumor when presenting in the salivary gland; branchial cyst if the presentation is below the gland; or lymphoma or lymphadenitis if the presenting site is lower in the neck.

Sialography is reportedly of little diagnostic value,[3, 12] since the displacement of the ducts indicates only a "space-occupying" mass. Aspiration biopsy and staining of the air-dried smears of the aspirates with May-Grunwald-Giemsa stain may permit a correct diagnosis in up to 83% of the cases,[16] but repeated biopsy may be required, and, in most cases, the patient will come to surgery anyway. The aspiration technique, however, has merit if the patient is opposed to surgical removal of the mass and malignancy needs to be excluded.

Treatment and Natural History

The Warthin tumor is particularly amenable to surgical removal. It is usually superficially placed,[3] and the facial nerve is rarely involved by the tumor. While well-defined, the tumor does not usually shell out easily, and this factor, with the desire not to spill the cyst contents, requires removal of adjacent gland.[11] Radiation may decrease the size of the lesion, but does not effect its regression[17, 18] and is not a substitute for surgical removal.

Recurrence rates are difficult to compute from reports because of insufficient follow-up. Six of 49 tumors encountered at Memorial Hospital manifested recurrence.[19] Incomplete excision, operative spillage of tumor contents, or more likely, growth from a new focus are held responsible. Multicentricity at first excision has been repeatedly noted.

Earlier reports of malignant Warthin's tumor have been refuted by many authors.[2, 3, 19, 20, 21] A case of **purported** malignant transformation with metastases has been reported by Ruebner and Bramhall.[20] However, an occult metastasizing thyroid carcinoma may be a more likely alternative. Two recent case reports, [21, 22] are more convincing. The patients, in both instances, had received irradiation to the neck, eight and 13 years earlier. In view of the fact that these two cases, of almost 600 cases of Warthin's tumor reported in the literature, are the only reasonably acceptable examples of malignancy certainly speaks for a **spontaneous** malignant propensity of such low order as to be non-existent. Involvement of the lymphoid component of the tumor by leukemia and by Hodgkin's disease has been reported.

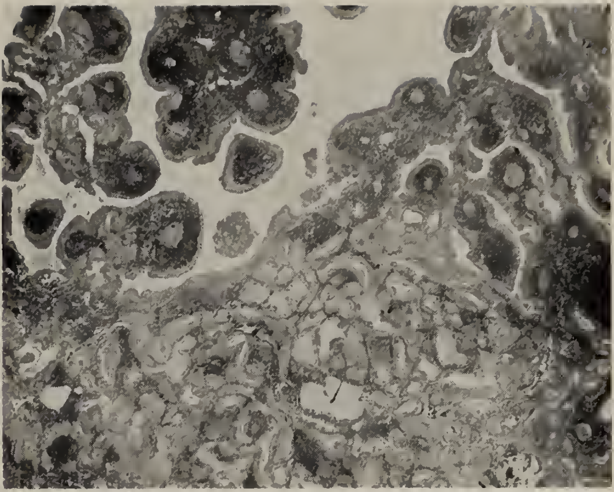

Figure 5: Fully developed papillary cystadenoma lymphomatosum in parotid gland.

Gross and Microscopic Features

The tumor is encapsulated and round or oval with a smooth or lobulated surface. It is usually cystic or semi-solid and compressible. A fluid of variable character but usually mucoid and browntinged, exudes from the cut surface. On section, multiple irregular cystic spaces with papillary projections are seen (Figure 5). Solid areas are grey and may manifest many small white nodules representing lymphoid follicles.

COHEN

CO-AUTHORS

Both Doctors Cohen and Batsakis are associated with the Department of Pathology, University of Michigan Medical School.

BATSAKIS

Microscopically, an epithelium having a tubulo-papillary-cystic pattern is within lymphoid tissue or a lymph node. The latter has sinuses, lymph follicles, and usually, an embracing connective tissue capsule. Lymph node architecture may be so compressed and distorted by the epithelial components that sinuses may not be readily evident, but follicles are usually seen.

The epithelium is a double layer of oxyphilic, finely granular cells; an inner layer of round, cuboidal or polygonal cells and an outer zone of non-ciliated, tall columnar or clavate cells. The nuclei of the inner cells are vesicular, while those of the outer layer are usually pyknotic and situated uniformly toward the luminal surface. Not all the cells have the same intensity of staining with eosin; some are pale and distinctly granular while others are intensely red and homogeneous. Mucus or goblet cells may be interspersed in the epithelial layer. A piling-up of epithelium or focal areas of squamous metaplasia occasionally may be seen. A fine basement membrane separates the epithelium from the lymphoid tissue.

Phosphotungstic acid-hematoxylin stains on paraffin embedded tumors demonstrate numerous fine, blue-black granules (mitochondria[23]) in the cytoplasm of both cell types in the epithelial layer. Positive histochemical reactions for phosphatases, esterase and various mitochondrial enzymes are demonstrable, but not in significantly greater degree than in normal parotid gland ducts, though certain qualitative differences exist.

Ultrastructural examination of the epithelial cell cytoplasm finds it packed with mitochondria in both apical and basal areas. Many are in groups, enlarged, and manifest increased numbers of cristae.[24] The staining variation noted under the light microscope correlates with the numbers of mitochondria in the cells.[25]

The fluid within the cystic spaces of the tumor and into which papillae project has a homogeneous or finely granular eosinophilic appearance.

Summary

The papillary cystadenoma lymphomatosum (adenolymphoma), or Warthin's tumor, is a benign tumor of the parotid gland or its immediate environs. It is a neoplastic growth of cells of ductal inclusions in lymph nodes in or adjacent to the parotid gland and this accounts for its biphasic (epithelial and lymphoid) structure. The tumor is usually asymptomatic and occurs predominantly in males between the ages of 40 and 70 years. Surgical removal is the only acceptable modality of treatment.

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MONTHLY SURVEILLANCE REPORT
CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
FOR THE FOUR-WEEK PERIOD ENDING SEPTEMBER 28, 1968

	1968 This 4-Week Period	1967 Same 4-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	11	21	275	940
Whooping Cough	36	71	357	815
Diphtheria	0	0	0	1
Mumps	133	239	13251	13202
Scarlet Fever & Strep Sore Throat	359	360	7652	10188
Tetanus	0	0	2	2
Poliomyelitis (Paralytic)	0	2	0	3
Hepatitis	194	154	1617	1464
Salmonellosis (Other than S. typhi)	34	58	489	414
Typhoid Fever (S. typhi)	0	1	0	7
Shigellosis	34	17	208	317
Aseptic Meningitis	130	10	184	48
Encephalitis	13	3	69	86
Meningococcic Meningitis	6	5	74	58
Influenzal Meningitis	5	2	42	43
Tuberculosis	236	217	2122	2210
Syphilis	377	383	4048	4203
Gonorrhea	1496	1518	13384	12738

MICHIGAN
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HEALTH

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Dietary Fat Restrictions and Atromid Therapy In Patients With Type II Familial Hyperlipoproteinemia

BY SHAFEEK S. SANBAR, M.D., PH.D.
ANDREW J. ZWEIFLER, M.D.
JAMES CONWAY, M.D., PH.D.
ALL OF ANN ARBOR

The three co-authors, Doctors Sanbar, Zweifler and Conway are all associated with the Department of Internal Medicine, University of Michigan Medical School.

The observation by Oliver[1-2] that Atromid* (clofibrate + androsterone) diminishes the concentration of serum cholesterol and triglyceride in patients with hypercholesterolemia and ischemic heart disease has been repeatedly confirmed.[3-5] Substantial reductions in serum lipids occur in patients with hypertriglyceridemia associated with an increased plasma concentration of very low density beta-lipoproteins.[4-7] On the other hand, patients with essential hypercholesterolemia or hyperbeta-lipoproteinemia, referred to recently as type II familial hyperlipoproteinemia,[8] in whom serum triglyceride concentrations are generally within the normal range respond relatively poorly to Atromid therapy alone.[4-7]

The following study depicts the effects of dietary fat restriction and Atromid therapy in 15 patients with type II familial hyperlipoproteinemia. Results show that the combination of diet and drug therapy produces substantial reductions in serum cholesterol in 60% of the patients.

Materials And Methods

Thirteen female and two male patients with type II hyperlipoproteinemia were studied (Table I). Their ages ranged from 6 to 58 years, and they all were normoglyceridemic. The average serum cholesterol concentration on no treatment and after a 12- to 16-hour fast was above 300 mg% on 2 successive determinations obtained two to four weeks apart. Paper electrophoresis of serum lipoproteins according to the modification of Lees and Hatch[9] demonstrated hyper-beta-lipoproteinemia. All patients had positive family history of hypercholesterolemia, and none of them showed either clinically or by laboratory tests evidence of a known cause for the hypercholesterolemia. Two patients (M.D. and D.D.) were mildly obese and two others (G.C. and P.A.) had diabetic relatives.

All patients were instructed in a diet with a total calorie content of 30-35 calories per kg body weight of which 15-20 per cent was fat, ⅔ unsaturated and low in cholesterol, 20 per cent was protein, and 60-65 per cent was carbohydrate. The patients were seen at monthly intervals in the fasting state for collection of blood and clinic evaluation. After a two-month-trial on diet alone, 1-2 g Atromid were given daily for two months, after which Atromid was withdrawn for two more months while the patients remained on the diet.

Fasting blood samples were analyzed for serum cholesterol and triglyceride by the methods of Connerty and co-workers[10] and Van Handel and Zilversmit,[11] respectively.

Results

Dietary fat restriction for two months produced only a slight decrease in the overall mean serum cholesterol concentration from pretreatment level (Table I), but five patients appeared to have reductions greater than 10%.

Atromid in addition to the diet produced further reductions of serum cholesterol in most of the patients. In nine of them, so-called "responders," serum cholesterol fell more than 15% after addition of Atromid. The mean serum cholesterol of the responders during "diet + Atromid" was respectively 26% and 21% below the mean values of "pretreatment" and "diet alone." Withdrawal of Atromid without change in diet resulted in a return of mean serum cholesterol to or towards the value observed initially on diet alone. In the remaining six patients, so-called "non-responders," there were only slight changes in serum cholesterol after diet and drug therapy. Also noted in Table I are the overall mean changes in serum cholesterol.

---

*Kindly supplied by the Ayerst Company.

TABLE I

Response of 15 Type II Hyperlipoproteinemic Patients To Therapy With A Low Fat Diet And Atromid*

Name	Age in yrs.	Sex	Triglyceride	Serum cholesterol in mg%			
				Pretreatment	Diet Alone 2 months	Diet + Atromid 2 months	Diet only 2 months
RESPONDERS							
V.F.	6	F	81	423	374**	245	308
C.C.	12	F	148	333	338	272	334
P.D.	14	F	156	420	451	362	378
M.L.	23	F	84	385	405	318	360
E.F.	39	M	91	386	363	232	290
G.C.	40	F	122	453	452	373	377
P.A.	44	F	135	375	286**	264	326
L.Dr.	46	F	139	493	417**	303	358
A.T.	56	F	115	585	547	486	545
Mean of responders			119	428	404	317	364
+ S.E.M.			14	25	25	27	25
NON-RESPONDERS							
L.C.	9	F	130	349	340	330	370
D.D.	16	F	118	650	607	696	600
J.T.	22	F	127	408	371	361	366
M.D.	36	F	140	384	324**	390	376
H.R.	47	M	170	365	326**	315	350
P.S.	58	F	89	460	443	393	427
Mean of non-responders			129	436	402	414	415
+ S.E.M.			11	46	45	58	38
Overall Mean			123	431	403	356	384
+ S.E.M.			7	23	22	30	22

* Dose of Atromid: 1 g/day for V.F., 1.5 g/day for C.C. and L.C., and 2 g/day for the rest of the patients.
** Greater than 10% decrease from pretreatment value.

Discussion

These data show that dietary fat restriction alone produces little change in serum cholesterol of patients with type II hyperlipoproteinema. On the other hand, Atromid in addition to the diet produces a substantial decrease in serum cholesterol in nine out of 15 patients studied; the remaining six patients have responded either poorly or not at all.

Earlier reports have indicated greater resistance of type II hyperlipoproteinemia patients to treatment with Atromid than we find here. Strisower[5] reported that in only two out of seven patients with this disorder did Atromid induce a substantial decrease in serum lipids and beta-lipoproteins. Howard and co-workers[4] also studied seven patients with this disorder. In two female patients Atromid produced a marked reduction in serum cholesterol, whereas in only one of five male patients was there a moderate response. Jepson and James[6] reported that Atromid therapy in 7 patients with idiopathic hypercholesterolemic xanthomatosis (presumably type II hyperlipoproteinemia) produced only a mean decrease of 9% in serum cholesterol, with a maximum response of 12.9%. The chief difference between the above three studies and our own is the very low fat diet which is mostly unsaturated. This may well be the reason for the greater responses in our patients.

Nevertheless, 40% of our patients with type II hyperlipoproteinemia responded either poorly or not at all to the combination for unknown reasons. One possibility is that 2 months of combined therapy is not long enough. Whether or not prolonged therapy with this combination may be of benefit to some of the "non-responders" is a matter for further study.

Summary

In patients with type II familial hyperlipoproteinemia dietary fat restriction for two months produced no significant reduction in concentration of serum cholesterol. Addition of Atromid (mixture of ethyl p-chlorophenoxyisobutyrate and androsterone) to the diet for two months produced greater than 20 per cent mean decrease in serum cholesterol in 60 per cent of the patients. Withdrawal of Atromid therapy without change in the diet resulted in a return of serum cholesterol to or towards the value observed initially on diet alone.

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Clinical Experience With Haldol (Haloperidol) In Chronic Schizophrenics

ABSTRACT: Haldol (Haloperidol), a non-phenothiazine tranquilizer revealed its effectiveness on chronic schizophrenics who are withdrawn and hostile. The daily maintenance dosage varied from eight to twelve milligrams. Fifty percent of the patients developed neuromuscular reactions but they were adequately controlled with Trihexphenidyl (Artane). No hypo-tensive reaction, blood dyscrasias, liver dysfunction, photo-sensitivity and convulsions were observed in this study.

BY B. S. YUN, M.D.
OWOSSO

LAWRENCE BANNER, M.D.
C. B. OVERBEY, M.D.,
KALAMAZOO

Haldol (Haloperidol), a butyrophenone derivative is a non-phenothiazine tranquilizer and has been used in Europe for the past ten years, although it is a new drug in the United States. This study was designed to investigate the clinical effectiveness in Schizophrenics.

Subjects

The subjects for this study were twelve female hospitalized patients who were on the disturbed ward and under close supervision because of their unpredictable behavior. These patients were chronic schizophrenics who were withdrawn, agitated, aggressive, hostile, delusional, hallucinating patients who were refractory to previous drug therapy, mostly phenothiazines, and electro-convulsive therapy. Their ages ranged from 19 to 58 years. Their period of hospitalization varied from 4 to 25 years.

Methods

Preparation:

All previous medications were discontinued for three days before initial doses of Haldol were administered.

To rule out blood dyscrasias, kidney dysfunction and liver dysfunction, the following laboratory tests were conducted: complete blood count, urinalysis, liver function tests, e.g., total protein, cholesterol, serum bilirubin, transaminase (SGOT), alkaline phosphatase, thymol turbidity. These tests were performed before starting treatment and were repeated bi-weekly for three months.

Temperature, pulse, respiration, blood pressure and weight were taken three times weekly during the period of treatment.

Dosage:

Initial dosage of Haldol was 0.5 mgs. three times a day for five days. It was then increased to 1.0 mgs. four times a day for five days, and then 2.0 mgs. four times a day for three days. Thereafter, according to clinical response to the drug the dose in some cases was increased up to 20 mgs. daily, for a period of three months.

Maintenance dosage in our experience ranged from 8 mgs. to 12 mgs. per day.

Performance Evaluation:

The patients on the ward were observed daily by the physicians, registered nurses, and psychiatric attendant nurses, who then rated the results after the three months of drug therapy.

Results

Clinical improvement was divided into five categories: Remarkable improvement (+++); moderate improvement (++); slight improvement (+); unchanged (O); condition exacerbated (—).

The results of the drug therapy are indicated in Table I.

TABLE I

Ratings	No. of Patients	
Remarkable improvement (+++)	2	50%
Moderate improvement (++)	3	
Slight improvement (+)	1	
Unchanged (0)	3	
Condition exacerbated (—)	3	

Target symptoms:

It was our clinical observation that the drug was most effective on improving personal appearance, contact with reality, cooperation, sociability and eating habits, and on reducing hostility, paranoid ideation, and auditory hallucinations (Table II).

TABLE II

Target symptoms	No. of cases improved
Personal appearance	3
Hostility	2
Contact with reality	2
Paranoid ideation	2
Cooperation	1
Sociability	1
Auditory hallucinations	1
Eating habits	1

Among these patients who have shown improvement:

Patient E:

This patient had been continuously hospitalized for the past 25 years, mostly on the disturbed ward. She was extremely paranoid, hostile, destructive, and assaultive to nurses.

She has shown moderate improvement, become more cooperative, sociable, and is no longer delusional after the three month period of drug therapy. She was transferred to a better ward where she could enjoy more freedom with fewer restrictions. The patient has been performing well in occupational therapy and has started to work regularly, and is attending typing classes. She started having home visits up to two weeks duration, unusual for many years.

Patient C:

This patient was hospitalized continuously for the past six years and has been quite paranoid with religious preoccupation, and complained of voices annoying her constantly. In addition she was quite manneristic.

She has shown moderate improvement, no longer has delusions, and voices are gradually disappearing. She was transferred to the better ward and allowed to have week-end home visits on a regular basis.

Patient L:

She has been schizophrenic for the past five years, delusional, and preoccupied with sexual ideas. She would giggle and laugh with silly facial expression at times.

She has shown marked improvement and started to have week-end visits at the end of three month's drug therapy. Eventually she was transferred to the better ward. She has done well in occupational therapy and has shown more initiative in social interaction. After having a 30 day successful home visit she went home on convalescent status recently.

Side Effects

Nausea and vomiting: 58% of the patients had nausea and vomiting during the initial three days with the dosage of 0.5 mgs. administered three times a day. This side effect was controlled with anti-spasmodics (e.g. Donnatal). It was noted as the dosage was gradually increased the nausea and vomiting did not recur.

Neuromuscular reactions: 50% of the patients developed neuromuscular reactions: tremor (3 cases), muscular rigidity (2 cases), and akathisia (1 case).

TABLE III

Side effects	No. of cases	
Nausea and vomiting	7	58%
Tremor	3	50%
Muscular rigidity	2	
Akathisia	1	

Correlation of dosage and neuromuscular reactions revealed their presence at dosage levels as low as 4 mgs. per day. In some cases neuromuscular reactions did not occur until the dosage reached 16 mgs. per day. Neuromuscular reactions in all cases were controlled adequately by administering trihexyphenidyl (Artane) with the daily oral dosage varying between 2 mgs. three times a day and 2 mgs. four times a day.

Summary

Haldol (Haloperidol) appears to be a potent anti-psychotic tranquilizing drug, especially useful in treating chronic Schizophrenics who are not amenable to the phenothiazine group of drugs.

It is effective in improving personal appearance, contact with reality, sociability, eating habits, auditory hallucinations, and reducing hostility and paranoid ideation.

Maintenance dosage varied from 8 to 12 mgs. per day in the patients in this study.

YUN

CO-AUTHORS

Doctor Yun, formerly, was chief psychiatrist of the female receiving unit, of Kalamazoo State Hospital, presently Director of the Shiawassee County Community Mental Health Center, Owosso, Michigan; Doctor Banner is a staff psychiatrist, and Doctor Overbey is assistant superintendent of Kalamazoo State Hospital, Kalamazoo, Michigan.

BANNER

In regard to side effects, 58% of the patients developed nausea and vomiting, but as dosage was increased gradually these symptoms disappeared.

50% of the patients developed neuromuscular reactions but these were adequately controlled with trihexyphenidyl (Artane).

Hypotension, skin reactions, blood dyscrasias, liver dysfunction, and convulsions did not appear in any cases.

Undesirable weight gain was no problem with Haldol.

Acknowledgement

We express our gratitude to the McNeil Laboratories for their supply of the drug, and the nursing staff of the Female Receiving Unit, the Van Deusen Building, Pharmacy, and the Clinical Pathological Laboratory of the Kalamazoo State Hospital for their assistance in this study.

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Sex Education Books Suggested

(Editor's Note: The following article includes an excellent bibliography to help physicians, educators, and others in their current efforts to work with Michigan communities, schools, PTA units, and others in the broad field of family life education and sex education).

The author, James S. Feurig, M.D., is medical director for the Health Center at Michigan State University and team physician for the Spartans.

The question of who should teach sex education to children and youth has always been a suppressed dilemma. It appears that the most effective program will involve comprehensive and well-organized teaching in the areas of: home, school and church.

The subject must be approached from the standpoints of: biology, heritage, morality and emotional pressure. A completely effective educational process will result in a fusion of these facets to the extent that the student will have a total concept of exactly what sex is.

It is too late to initially start sex education at the college level. This is something which has to be a part of child development and must be presented in the curriculum of elementary and secondary education. It should ideally be an extremely well-planned and step educational process which starts in kindergarten and progresses through high school. The teachers must have special training and be most competent. This should never be an area to "relegate" the teaching.

If the school, home, and church infinitely work together, the sex education program will be a very effective means to relate to young people the true meaning of sex and all of its implications.

Some selected reading sources which are apropos to the concerned age groups in this area are as follows:

For Children:

What is a Human. Alexenburg, Benefic Press, Chicago, 1964; *The Baby.* Ets, Marie Hall, Viking Press, 1953; *The Wonderful Story of You.* Gruenburg, Sidonie; *The Wonderful Story of How You Were Born.* Gruenburg, Sidonie; *And Now, Miguel.* Krumgold, Joseph. Crowell, 1953; *A Story About You.* Lerrigo, Dutton, $3.50; *The Question and Answer Book About the Human Body.* McGovern, Ann. Random; *Wonders of the Human Body.* Ravelli, Anthony. 1954; *How Your Body Works.* Schneider, Herman and Nina, Young Scott (10-14); *From Egg to Chick.* Selsam, Millicent; *All About Eggs.* Selsam, Millicent, Young Scott. $2.50; *Gypsy.* Seredy, Kate. Viking.

For Youth:

A Is For Anatomy. Cosgrove, Margaret. Dodd, 1965, $2.99; *Growing Up, How We Become Alive, Are Born, and Grow.* de Schweinitz, Karl MacMillan, 1963. $3.24; *Love and Sex In Plain Language.* Johnson, Eric. Lippincott. 1965; *How Life Begins,* Power, Jules. Simon and Schuster. $3.95; *Animals As Parents.* Selsam, Millicent. Morrow. $2.95.

What Is This Thing Called Health Education?

BY WM. H. CARLYON, PH.D.
CONSULTANT IN HEALTH AND FITNESS
AMERICAN MEDICAL ASSOCIATION

The low regard that many teachers and administrators have for health education is astonishing. This may seem parodoxical in light of the fact that health has been considered as a cardinal principle of education since 1918. But, health, like motherhood, is easy to be **for** without really understanding what is involved. In practice there often appears to be little relationship between our expressed devotion to the health of the school child and what we actually do about it.

Part of the problem is semantic. The term education itself refers to a complex abstraction about which people seldom communicate with precision, and even when they do they seldom agree. Add to this the similarly un-understood term "Health" and the opportunities for confusion multiply astronomically.

Perhaps things are not quite as bleak as all this. For instance most educators do know that there are three major areas of activity in school health: Health Services, Healthful Environment, and Health Education.

The first involves arrangements for such health services as periodic physical exams, immunizations, tuberculosis screening programs; and emergency care for the child who becomes ill or injured at school.

The second is concerned with providing a school environment which minimizes hazards and enhances the learning process. This includes a healthful emotional climate within the school, non-skid floors, accessible exits, proper heating and lighting, cafeteria sanitation.

These two areas, health services and healthful school environment are easy to visualize and comfortable for the educator to live with because they most often involve tangible, measureable objects and procedures, and are usually the primary responsibility of someone other than the classroom teacher.

The third area — health education — is very different because it **must** be an integral part of the instruction program. It is by nature intensely personal and practical to the student and is designed to help him learn how to live in a manner that will enhance health and discourage disease. The primary goal of health education is to prevent illness, not cure it.

TO FULLY APPRECIATE the importance of health education and its role in the prevention of illness it is necessary to be aware of the nature of the major threats to life and health in this country and how they have changed since the beginning of this century.

Very briefly the change has been from communicable diseases initiated by specific pathogens to chronic and degenerative disorders and accidents — conditions which often have no single cause but do stem from patterns of living adhered to over periods of many years.

It is, particularly, important to note that the methods used to bring the major communicable diseases under control have only limited application to most of our major health problems today. For example, even the most sophisticated sanitation and immunization measures or the most elaborate care and treatment facilities do relatively little to prevent **new** cases of cardiovascular disease, cancer, diabetes or mental illness.

Medical treatment in response to symptoms cannot always limit the incidence of most "modern" diseases. We cannot feel arteries hardening or fatty deposits building up in them, and it is a truism that the emotionally ill person is the last to admit that he needs help. When we respond to symptoms it is often too late to prevent serious illness.

FUTURE ADVANCES IN improving the health of the public will necessitate individual, voluntary, positive health behavior that leads to prevention of disease or its detection at a stage in which it can be most readily reversed or arrested.

Health education does have a vitally important role to play in early detection of disease but the fact remains that the only hope for primary prevention of many of our health problems is to help

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This article was first presented by Doctor Carlyon as an address before the 1968 Northern Michigan Health Conference at Houghton.

young people establish early in life patterns of behavior which we know will enhance health and discourage disease. This is what school health education is all about.

WHAT ARE SOME of these behavior patterns? Here are a few that help to determine the state of a person's health at any given time.

1. How he has handled his feelings under stress since childhood.
2. What value he has placed upon himself as a person since childhood.
3. What level of physical activity he has maintained since childhood.
4. What kind of a diet and how much food he has eaten since childhood.
5. What level of immunity to pathogens he has maintained since childhood.
6. How wisely he has utilized available health products and services . . . since childhood.
7. How well he has avoided accidents since childhood.
8. How many cigarettes he has inhaled since childhood.

Behavior patterns such as these which make up individual life styles, begin forming very early, long before a child goes to school. They are motivated by information and feelings and are learned from others.

Although no amount or kind of "healthful living" can guarantee an illness-free life, we do know enough about physical and mental health and about human development to know that such behavior patterns individually and, most often, in combinations have much to do with whether an elementary school child will become:

1. A drug dependent hippie at 20.
2. A welfare dependent divorcee at 25.
3. A mental patient at 30.
4. A heart attack victim at 40.
5. Or will die of lung cancer at 50.

The purpose of health education is to help children establish early in life patterns of living which we know will discourage just such tragedies and in the process allow them to fulfill themselves to the maximum of their capacities.

IN THE FACE OF all this that we know, it is inconceivable that we should continue to place such a low value upon health education in our schools as we have in the past. Learning how to live a healthful and satisfying life is every bit as important as learning how to add, or being able to recite the parts of speech, or knowing the major exports from Brazil.

It is not that the rest of the curriculum is unimportant. Everything a student learns at school can contribute to his overall well being. But, nothing is **more** important than learning how to live a healthful life.

There is a lot of activity labeled health education going on in schools and colleges across the country. Some of it is excellent. But a great deal of what is so labeled isn't health education at all. It is illness education — because it is being used as an antidote for health problems that have already developed, and such problems often turn out to be the dramatic ones which scare the daylights out of the adult community — sexual misconduct, unwed pregnancy, venereal disease, drug dabbling, and reckless driving.

CERTAINLY WE ARE IN favor of doing whatever we can to cope with such problems; but it is just as important to help young children learn to deal constructively with their impulses to aggression and gratification, as it is to bring a narcotics agent into the classroom in an effort to frighten teenagers out of using drugs. It is just as important to help children gain a knowledgeable awareness of their evolving sexuality as it is to have a crash sex education program in junior high in response to a pregnancy epidemic.

The story of health education in our schools has often been one of too little and too late. Unfortunately it is getting later and later and we still aren't doing enough about it.

TOO LITTLE, TOO LATE has also been a pattern in American life, particularly, regarding

AUTHOR
WM. H. CARLYON, M.D.

our health and social problems. Somehow we find it easy to accept the old myth that we can solve any problem that develops through application of good old American ingenuity and know-how. Science and medicine have done much to alleviate suffering and to prolong life and there will continue to be exciting breakthroughs in the health field. But much of what has been discovered in recent years supports the thesis that many of our major health problems are due to lives poorly lived and that you cannot change a lifetime of destructive health behavior with a magic pill or gadget. We cannot afford to wait until we can get a "safe" cigarette from the tobacco companies or a guaranteed heart transplant in our local communities. It is tragic if we pass blind faith in science and technology on to our children.

All of our future health problems exist, potentially, in our present school populations. The nature of these problems will be determined in large part by how these students live their lives during the next 20-30 years. If we really want to do something about these future health problems the time to start is now, and the place to begin is our schools.

We need comprehensive, balanced health programs in every school, including adequate health services, healthful school environment, and planned health education experiences from kindergarten through college. It would seem logical to place a special emphasis on the elementary schools where we can reach children at a time when their attitudes and life styles are still in formation.

NONE OF WHAT HAS been said here is intended to pose health education as a panacea. It isn't. But health education can be a major force in helping young people learn how to live constructively and healthfully with the demands of an environment which often appears to stretch the limits of human adaptibility.

The evidence in support of sound school health education is overwhelming.

It is time for action.

Hypercatabolic and Non-Oliguric Renal Insufficiency

BY J. C. ROSENBERG, M.D.
DETROIT

(Editor's Note: Following is an abstract of a paper on "A Study of Hypercatabolic Non-Oliguric Renal Failure in Man," given by Jerry C. Rosenberg, M.D., at a meeting of the Detroit Surgical Association. Doctor Rosenberg is associated in the Department of Surgery at Wayne State University Medical School.)

Postoperative and post-traumatic patients with renal insufficiency have twice the mortality of medical patients with anuria. In an attempt to understand the reasons for this disparity in prognosis, we have studied, in detail, 6 patients with renal failure; in each instance this complication followed a major operation or massive trauma and fell into the category of either hypercatabolic (daily increase in blood urea greater than 60 mg/100 ml) or non-oliguric (elevation of blood urea and creatinine despite normal daily urine volumes) renal insufficiency. Hypercatabolic oliguric renal failure and non-oliguric renal failure result from a reduction in renal blood flow.

The severity of the tubular damage and the extent of the associated catabolic state determines which of the aforementioned syndromes will be produced. Infection and/or the presence of necrotic tissue was responsible for the hypercatabolic state in all of the patients. Previous renal disease was present in 2 of the 6 patients. From a therapeutic point of view, it is essential to differentiate the varieties of renal insufficiency. Failure to recognize these syndromes, and therapy which was too conservative, was responsible for the high mortality of 33%.

Adequate treatment requires the early onset of continuous peritoneal dialysis or the insertion of an external Scribner shunt and daily hemodialysis. Simultaneously, necrotic or infected tissue must be excised or physiologically eliminated by hypothermia.

Wine in Medicine

BY ARMANDO R. FAVAZZA, M.D.
ANN ARBOR
AUTHOR

Undoubtedly there is something basically majestic in wine, like blood or bread or lentils. Priests have consecrated it, poets sung paeons to it, philosophers praised it, physicians prescribed it. Perhaps it is merely coincidence, but the countries which have given art and "joi de vivre" to the world also include wine as a staple of life.

There are more than enough historical admonitions exhorting the use of wine as a medicine. In the Hebraic Talmud, wine is called "the foremost of all medicines." The physician Maimonides wrote about wine, "It contains much good and light nourishment. It is rapidly digested and helps to digest other foods. It also removes the superfluities from the pores of the flesh and excretes urine and perspiration."

The Book of Proverbs states, "Give strong drink unto him that is ready to perish, and wine unto those of heavy hearts." And St. Paul advised Timothy to, "Drink no longer water, but use a little wine for thy stomach's sake and thine often infirmities."

Hippocrates wrote, "No wounds should be moistened with anything except wine unless the wound is in a joint." Galen used wine to bathe the intestines of wounded gladiators before stuffing them back into the abdomen in order to prevent infection.

During the Renaissance wine was used as a rinse to decrease dental caries, and also as a stimulant for the liver and pancreas.

Pasteur declared that wine was ". . . the most healthful, the most hygienic of beverages." Wine was added to water and prescribed in France and Austria to combat typhus and cholera.

Pharmacology

The pharmacological properties of wine are far more varied than those produced by alcohol alone. Table wines average about 13 percent alcohol and fortified wines (sherry, port) about 20 percent alcohol. The pH of wine is 3.2, approximately that of gastric secretions. Wine alcohol is more slowly absorbed from the gastrointestinal tract than straight alcohol or alcohol and water, thus a great quantity must be drunk to cause a high alcohol blood level. Being a natural tranquilizer it has few side effects and may be considered as a mild hypnotic-sedative.

Because of their tartrate content, white wines serve as mild diuretics. The high K/Na ratio is favorable for the cardio-vascular renal system.[1]

The anthrocyanins, which contribute to the color of wine, are antibiotic in low concentrations and are especially effective against shigella, salmonella and typhoid.[2]

Cyanidol, which occurs as 1-3000 parts per million in wine, may act to reduce hypercholesterolemia.[3]

Wine also contains amounts of the vitamin P group (bioflavenoids) in sufficient quantity to be effective in maintaining the integrity of capillary structure.[4] Almost all the B vitamins are present in great enough quantity so as to be considered as a supplemental source.

Due to enzymes found in wines it has been reported that in some malabsorption syndromes, white wine with meals may restore fat absorption to normal.[5] The ferrous iron in wine is, of course, easily absorbed.

An average glass of wine contains about 95 calories, dry wines having lower sugar content. Insulin is not required to metabolize the alcohol in wine, and wines have been prescribed as part of a diabetic diet.[6]

It has been recently reported that one-half a liter of wine will lower intraocular pressure significantly in patients with glaucoma.[7]

Contraindications

Wine should not be prescribed for patients with the following conditions:

1. Alcoholism — except under controlled conditions when wine may deliberately substitute for crasser and more potent alcoholic beverages.
2. Specific allergy to wine.

The author, Doctor Favazza is a resident in the Department of Psychiatry, University of Michigan Medical School; and president of the Physician's Wine Appreciation Society of Greater Detroit.

3. Esophagitis or gastritis.
4. Pancreatitis.
5. Genito-urinary tract infections.
6. Prostatitis or benign prostatic hypertrophy.

Indications

While we might try to fool ourselves about the important pharmacological effects of wine there are more potent and specific agents we can use. Wine is a fine and neglected auxiliary nostrum, especially in elderly patients.

A glass of wine with a meal will make a drunkard of no one and it may help to alleviate minor tensions and may "promote geniality, conviviality, companionship, interest in others, appreciation of the environment, and overall bodily comfort."[8]

In a loosely-controlled large California study the authors conclude: "Whatever the physiological or psychological mechanisms involved, it seems obvious that the inclusion of small amounts of wine in hospital diets resulted in a substantial relaxation of tensions, indicated by a substantially lower number of complaints per patient. The use of wine with meals not only improved the palatability of the food with which it was served, but appeared to make the coffee taste better, reduce the unpleasantness of hospital smells, make the room seem less noisy, increase the courtesy and efficiency of receptionists and carriers, and generally improve the rapport between the patients and the physicians, nurses and technicians."[9]

A glass of port at bedtime may combat mild insomnia. An afternoon glass of sherry is a genteel custom to open the appetite, combat boredom and lead to relaxation. Sherry has also been prescribed to combat premenstrual tension due to its mild diuretic and tranquillizing properties. Champagne is a favorite European remedy for post-partum "blues."

Wine given to a hospitalized patient may do wonders for the hospital's image as a place where one comes for living and not for dying. Although wine is a staple of life throughout the world, in America it stirs up middle-class images of gracious living. Osler called wine "the milk of old age."[10] As our methods and mentalities become more mechanized, a glass of wine may be a thoughtful gesture, a touch of civility, an inexpensive way of expressing care and kindness.

It is not necessary to prescribe high quality, high-priced wines. Michigan is one of the nation's largest wine producing states and its wines, when bought in bulk, are negligible in price. Bulk wines are cheaper than fruit and vegetable juices and may be good replacements on the hospital evening cart!

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Editorial Comment:

Whether one is a teetotaler or not, many physicians will certainly enjoy reading this brief description of the use of wine in medicine. One could draw the reader's attention especially to its value as a psychological boost to the patient as herein described. (John W. Moses, M.D.)

Four-Year MSU Medical School Supported in Annual Address by Harris

A proposal that citizens, concerned with the supply of doctors in Michigan, help complete a four-year medical school at Michigan State University was made by the president of the Michigan State Medical Society at the 1968 Annual Session.

President B. M. Harris, M.D., Ypsilanti, suggested the "formation of citizens committees in Michigan communities to help support the efforts to graduate future doctors at MSU."

Doctor Harris declared, "The State Medical Society should strongly urge the development of citizen groups to augment physician appeals to the state legislature to provide the support necessary to expand the two-year MSU medical school to the full four years."

The State Board of Education has recommended the expansion of the two-year MSU school to a MD degree granting institution, but the legislature, to date, has not voted the necessary funds for expansion.

Greater use of community leaders to help increase the number of doctors trained in Michigan was advocated by Doctor Harris. In part, he said, "Medicine would like to ask the help of intelligent and dedicated laymen to aid in increasing the quantity and quality of medical care we can offer our patients."

"The doctors of medicine," reviewed Doctor Harris, "have endorsed for several years the expansion of the two-year MSU school to become the third medical school in Michigan."

Every effort must be attempted to close the gap between public demand for medical services and the number of Michigan doctors of medicine, Doctor Harris said. "Our greatest prospect lies in funding by the legislature to expand the medical schools at the University of Michigan and Wayne State University and to obtain a four-year medical school at MSU."

B. M. HARRIS, M.D.

Doctor Harris pointed to a recent Brookings Institute Report on the doctor shortage. The Institute predicts that the demands for medical services in the 1965-75 decade will increase between 22 and 26 per cent, while the supply of physicians will increase by less than 20 per cent.

In his annual report, Doctor Harris said, "Although there is a strong basic science program at Michigan State and a new life sciences building, the present great need there is financial support. More state funds must be appropriated by the state legislature to develop the clinical areas of the medical school curriculum."

MSU began its two-year school in the fall of 1966.

Information about the seriousness of health quackery was stressed in comments to the Michigan State Medical Assistants Society convention by Brock E. Brush, M.D., left, Detroit, Chairman of the MSMS Public Relations Committee, and James J. Lightbody, M.D., MSMS President.

Photo Highlights From Annual Session

OTHER PHOTOS APPEARED IN OCTOBER EXTRA; MORE NEXT MONTH

Harry Dowling, M.D., right, of Chicago, who gave a speech about "Government, Medicine and Drugs" at one of the Annual Session Luncheons, visits with A. Martin Lerner, M.D., Detroit, a member of the Annual Session Program Committee.

James J. Lightbody, M.D., receives a Past Speakers Pin from Speaker James B. Blodgett, M.D., as one of the special ceremonies during the Annual Session. Doctor Lightbody had served as Speaker for eight years through the 1967 session, when he was chosen as President-Elect.

State Auxiliary officers were part of the receiving line for the Presidents Party during the Annual Session in the Sheraton-Cadillac Grand Ballroom. The couple at left is Dr. and Mrs. Earl Weston, Detroit, and the couple at the right is Dr. and Mrs. W. G. Gamble, Jr., of Bay City. Mrs. Weston is the new President of the Woman's Auxiliary to MSMS for 1968-69, and Mrs. Gamble is the outgoing President.

Table signs marked the locations of the county society delegations at the House of Delegates meeting of the Michigan State Medical Assistants Society annual meeting at the Pontchartrain Hotel.

Miss Helen A. Schulte, who serves as staff assistant for many of the MSMS scientific committees, was honored by the House of Delegates for 25 years of loyal, efficient service. Robert J. Mason, M.D., pointed out that Miss Schulte is the second MSMS employee to complete a quarter of a century of employment — the other was William J. Burns, who retired several years ago as the executive director.

dgett M.D
the House

Robert J. Roney, right, MSMS controller, receives warm congratulations of Robert J. Mason, M.D., when the House of Delegates honored Mr. Roney for 20 years of loyal, efficient service.

George L. Reno, M.D., Detroit, presided at the 1968 MDPAC Breakfast in Detroit during the Annual Session. Doctor Reno, Secretary of the Wayne County Medical Society, is a member of the MDPAC Board of Directors.

In photo below, James J. Lightbody, M.D., Detroit, gives his message as president-elect to the 1968 House of Delegates.

Every year during the MSMS Annual Session, the former leaders of the State Society get together for a social evening and the chance to discuss projects they helped carry out for MSMS. The 1968 dinner meeting was held at the Detroit Athletic Club.

Past MSMS Officers In the Camera Eye

AT LEFT — D. Bruce Wiley, M.D., right, formerly of Utica and now of Lansing, former Chairman and Secretary of The MSMS Council, exchanges comments with Gerald D. Dorman, M.D., New York City, President-Elect of the AMA.

Three former MSMS officers visit with Gerald D. Dorman, M.D., AMA President-Elect, at the Past Officers Dinner. Left to right are H. R. Carstens, M.D., Detroit, who was speaker in 1928-29; Doctor Dorman; L. W. Hull, M.D., Detroit, President in 1953-54; and Luther R. Leader, M.D., Royal Oak, President in 1965-66.

Three past presidents are caught in the middle of a good story — Left to right are Kenneth H. Johnson, M.D., Lansing, President, 1960-61; George W. Slagle, M.D., Battle Creek, President, 1957-58; and G. B. Saltonstall, M.D., Charlevoix, President, 1958-59. Doctor Johnson currently serves as the MSMS Secretary.

C. Allen Payne, M.D., left, Grand Rapids, President during 1966-67, tickles the funny bone of Hugh W. Brenneman, Executive Director.

In photo above at left, B. M. Harris, M.D., visits with two visiting dignitaries. Newton DuPuy, M.D., President of the Illinois State Medical Society, is center, and Robert Howard, M.D., Past President of the Ohio State Medical Society, is at right.

Orlen J. Johnson, M.D., right, Bay City, President of MSMS during 1963-64, talks about health planning with George W. Slagle, M.D., Battle Creek, President during 1957-58. Between the two in the background is Otto B. Beck, M.D., Birmingham, President during 1951-52.

BELOW — Otto K. Engelke, M.D., left, Ann Arbor, MSMS President in 1961-62, discusses current medical issues with Oscar D. Stryker, M.D., Mt. Clemens, former Speaker of the MSMS House of Delegates in 1940-41 and 1941-42.

MSMS Offers Advice on Transplants To State Legislative Committee

The Michigan State Medical Society has pledged its complete support to the new Michigan Legislative Committee on Transplants of Human Body Parts.

The medical society has informed the committee chairman, Senator N. Lorraine Beebe, that its members who are well informed in this field are available as resource persons, and that its extensive files of technical reports and scientific papers are at the disposal of the committee.

When the committee conferred in Lansing, October 9, C. Allen Payne, M.D., of Grand Rapids, a past president of the state medical society, was present as an invited resource expert.

Doctor Payne and Senator Beebe attended a conference in Washington, D.C., September 30 on "Medical-Legal Issues Relating to Tissue Transplantation." The meeting was sponsored by the National Research Council.

MSMS also helped arrange for Senator Basil Brown, who introduced the resolution creating the committee, to attend a special American Medical Association-sponsored program in June on "The Limits of Medical Responsibility in the Prolongation of Life."

The Michigan legislature on January 11 adopted a resolution to create the Special Committee on Transplants of Human Body Parts. The resolution, introduced by Senator Basil Brown, also outlined the broad functions of the committee in preparation of a report to the 1969 legislature.

The special committee has been appointed to include five senators and five representatives, with Senator N. Lorraine Beebe as chairman and Representative William L. Jowett as vice-chairman.

The legislative resolution praised the recent successes of surgical transplants of human body parts for bringing "new hope for all in the never ending battle against disease and accidents," and pointed out "that the same successes raise new legal and moral questions for which answers do not presently exist."

The resolution declared further, "it is in the public interest that these questions be answered to the end that such research can be continued."

The special joint-legislative committee has been charged, "to study all phases of the subjects of transplants of human body parts and to report its findings and recommendations to the 1969 legislature."

The membership of the Human Transplant Committee includes the following State Senators—N. Lorraine Beebe, Chairman, Harry A. DeMaso, James G. Fleming, Basil W. Brown and Roger E. Craig; and State Representatives William L. Jowett, Vice-Chairman; Peter Kok, Dale Kildee, Daniel S. Cooper and Thomas L. Brown.

Attorney General Frank Kelley (in a "Know Your Michigan Law" newspaper column) on February 19, 1968, declared in part:

"Fortunately the Michigan legislature has provided answers to many of these questions (about transplants) by passing Act 82, of the Public Acts of 1958, as amended. The legislation authorizes and regulates the donating of all or any part of the human anatomy for various purposes."

Attorney General Kelley in May called for action to give firmer legal foundation for heart transplant operations in Michigan.

He declared that "the major task of the law is to facilitate the supply of anatomical parts needed for medical education and transplant purposes."

Attorney General Kelley said, "If science can make the startling breakthroughs that it has in the transplant area, with the difficult problems it was required to surmount, certainly we can make the necessary efforts to make the law a more helpful tool in this life-saving process. We certainly have the obligation to try."

"New legislation providing more definite rules is necessary," Attorney General Kelley said, "if we are to facilitate transplants through donation by the deceased's survivors."

He reported that there is no Michigan legislation regulating consent of the deceased's survivors to removal operation for transplant purposes. He pointed out, "however, a criminal statute which makes it a felony to mutilate any portion of a dead body without lawful authorization does set some limits."

The Attorney General indicated that possible new legislation should be "passed after lawyers, doctors and other concerned and informed citizens have played a part in giving it content."

Attorney General Kelley suggested the law should protect the doctors involved in removal operations against legal liability, and the law should constantly strive to provide the maximum feasible amount of certainty regarding the legal rights of all concerned."

Attorney General Kelley said, "Michigan law, fortunately, affords licensed medical practitioners and medical and educational institutions protection against civil liability for removing organs given as provided in the act where the gift has not been revoked."

Available as a guide for the Michigan legislative committee and the Michigan legislature as it considers possible new laws is the new "Uniform Anatomical Gift Act." This act was developed by the National Conference of Commissioners on Uniform State Laws and then endorsed by the American Bar Association.

The National Conference of Commissioners on July 30 gave approval to the uniform act, which it reports was "designed to facilitate donations and use of organs and other tissues for transplantation and other medical purposes."

The American Bar Association House of Delegates in August approved the uniform act and urged adoption by the state legislatures.

The proposed act will be distributed to all state legislatures as a nationwide model.

The matter of transplants also is under discussion in Congress. Senator Walter F. Mondale in 1967 proposed a Commission on Health, Science and Society to study transplants and many other matters which he called "profound and complex questions of law, ethics, and public policy."

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11 Michigan Physicians Honored For Volunteer Service in Vietnam

Eleven Michigan doctors of medicine who have served as volunteers in Vietnam this past year were honored at the 1968 Michigan State Medical Society meeting in Detroit.

Plaques for meritorious service were presented the doctors by Gerald D. Dorman, M.D., New York City, president-elect of the AMA.

The Michigan physicians, who each served two-month stretches for a total of 22 months, are:

Daniel D. Chapman, M.D., Owosso;
J. Colin Elliott, M.D., Buchanan;
Joseph A. Grady, M.D., Detroit;
Seymour Krevsky, M.D., Detroit
Armand M. LaSorsa, M.D., Manistique;
Donald Lipsey, M.D., Durand
Adrian J. Neerken, M.D., Kalamazoo;
Leonard M. Pickering, M.D., Southgate;
Henry C. Scharnweber, M.D., Midland;
Roger A. Scholten, M.D., Kalamazoo; and
Daniel B. White, M.D., Birmingham

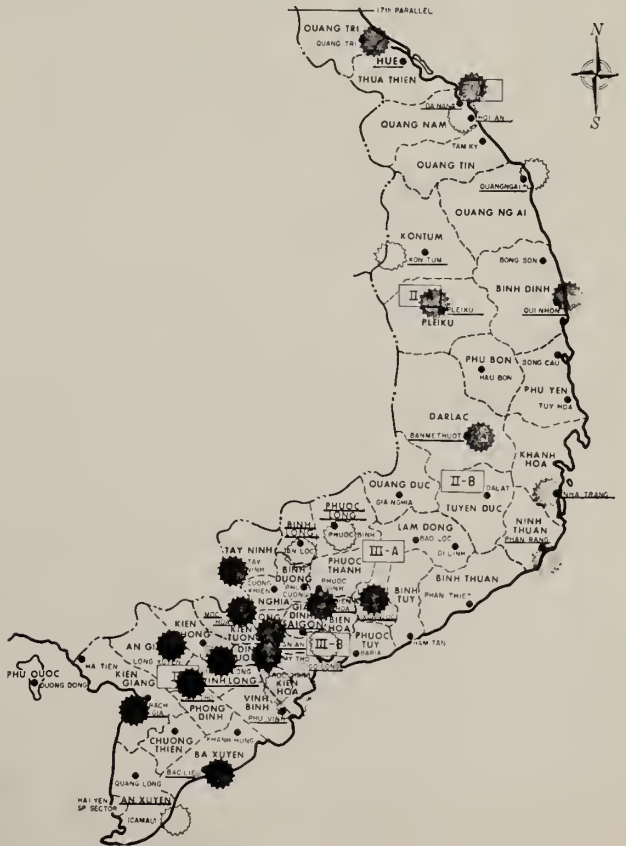
The awards were "Certificates for Humanitarian Service," and recognized the doctors of medicine "for treating the ill and injured during his medical mission."

The physicians and their wives were guests of MSMS for dinner before the House of Delegates session. Hira Branch, M.D., Flint, chairman of the MSMS International Medicine Committee, was the host.

Three Michigan physicians were honored a year ago. Since then the medical society has conducted a more active educational effort to get more Michigan doctors to volunteer for two months.

The AMA Physician Volunteers for Vietnam Program began three years ago and has sent more than 500 doctors to help the civilians in South Vietnam.

The map of South Vietnam shows the locations of physicians serving on AMA Volunteers Project. The current locations are marked with grey seal-shapes and former locations are in outline seal-shapes.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U-M Creativity Symposium Open To All Dec. 1

Michigan physicians are invited to participate in the "Symposium on Creativity, Conformity and Concepts of the 20th Century Adolescent," December 1 at the Sheraton Motor Inn in Ann Arbor.

A banquet, at 6:00 p.m., will feature an address, "Changes in Society's Procedures for Handling Juvenile Delinquency," by the Honorable Orman W. Ketcham, Judge, Juvenile Court of the District of Columbia.

All persons attending the symposium are invited to this banquet. Requests for banquet tickets should be forwarded together with personal checks ($5.00) made payable to "Symposium on Adolescents" and mailed to Department of Postgraduate Medicine, W5610 University Hospital, Ann Arbor, Michigan 48104.

The symposium is open to all physicians, their wives, and professionally allied colleagues. Members of the law profession who are closely concerned with medicolegal problems are also cordially invited. No registration or other fees are required for the lectures; however, because of seating space limitations, only those holding complimentary admission tickets can be accommodated. Further information and ticket applications will be sent to Michigan physicians or may be obtained by addressing requests to: Harry A. Towsley, M.D., Chairman, Department of Postgraduate Medicine, University of Michigan Medical Center, W5610 University Hospital, Ann Arbor, Michigan 48104.

The conference will be sponsored by the U-M Departments of Psychiatry and Postgraduate Medicine, the Michigan Society of Neurology and Psychiatry, and MSMS.

The symposium will explore the more recent trends in the general attitudes of youth, their sex mores, value systems, and psychological approaches to the search for identity. The entire program is designed for the benefit of the practicing physician who is now increasingly expected to deal firsthand with these problems.

The symposium has been made possible by an educational grant-in-aid from and with the assistance of Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York.

The first speaker at 1:15 will be Raymond W. Waggoner, M.D., U-M, on "The Adolescent Patient," followed by E. J. Hornick, M.D., Albert Einstein College of Medicine, on "Parentage and Parenthood Versus Creative Adolescent Turmoil."

Other afternoon speakers will include Fritz Reidl, Ph.D., WSU, on "Rebellious Youth and the Futility Syndrome;" Daniel Offer, M.D., Michael Reese Hospital, on "Sexual Problems Faced by Today's Normal Adolescent Girls;" and Dave L. Farnsworth, M.D., Harvard University, on "Adolescents' Abuse of Illicit Drugs; Facts Versus Fallacies."

MARMP GETS $1,652,273 GRANT

Albert E. Heustis, M.D., executive of the Michigan Association of Regional Medical Programs, has announced that MARMP organization has been awarded a $1,652,273 grant by the U.S. Public Health Service for educational programs and other studies to combat heart disease, cancer, stroke and related diseases.

Part of the grant will support the central coordinating staff in Heustis' office. The grant will also be used to finance projects designed to improve care of patients who have the diseases and to support planning staffs at three state universities and the State Public Health Department.

SEEK BIOMED PAPERS FOR U-M PROGRAMS

Interested physicians are invited to submit papers for the 7th National Biomedical Sciences Instrumentation Symposium, May 19-21 at the University of Michigan. Abstracts must be received no later than December 15 by Ernest E. Sellers, Host Chairman, Box 618, Ann Arbor 48107.

The conference, "Imagery in Medicine," will be sponsored by the University of Michigan and the ISA.

For more news about Coming Events read the four blue pages in the middle of this issue and every issue of *Michigan Medicine;* and watch for the *News Extra* during the middle of each month.

Walt Appointed Associate Dean; Other Changes

Several administrative appointments have been announced by Ernest Gardner, M.D., Dean of The Wayne State University Medical School.

Alexander J. Walt, M.D., since 1964 Assistant Dean at the medical school, has been appointed Associate Dean. He holds The Grover C. Penberthy Chair in Surgery.

Lawrence Power, M.D., who joined the medical faculty in 1965 as associate professor of internal medicine, has been named Assistant Dean. In his new position, Doctor Power will be responsible for the clinical implementation of the school's new curriculum. He will also represent Wayne State University as co-director of the Institute of Gerontology, serving with a representative of the University of Michigan.

Windsor S. Davies, M.D., clinical professor of ophthalmology and a member of the faculty since 1949, has been appointed Acting Chairman of the Department of Ophthalmology, filling the vacancy created by the retirement of Albert D. Ruedemann, M.D.

Ralph G. Smith, M.D., professor of occupational and environmental health and member of the faculty since 1955, has been appointed Acting Chairman of his department. Arthur J. Vorwald, M.D., chairman since 1954, has taken a long-term medical leave.

Ben Rubenstein, Ph.D., Director of Admissions and Student Advisement, is on sabbatical until July 1, 1969 to conduct research on admission policies and practices. Harry Maisel, M.D., professor of anatomy, has been named Acting Director.

MRS. GAMBLE NAMED TO REGIONAL POST

Mrs. W. G. Gamble, Jr., immediate past president of the Woman's Auxiliary to MSMS, has been appointed North Central Regional Safety and Disaster Preparedness Chairman for the National Auxiliary.

Mrs. Gamble, who will serve 12 states, participated in the North Central Regional Workshops, October 14-15 in St. Louis.

The annual fall conference of the national Woman's Auxiliary in Chicago in September was attended by Mrs. Earl Weston, current Michigan president; Mrs. Edward S. Maxim, president-elect, and Mrs. Gamble.

MEDISCENE

Nov. 6 — The Council, MSMS Headquarters, East Lansing

Nov. 10 — MSMAS Officers' Workshop, Port Huron Motor Inn, Port Huron

Nov. 11-15 — American Public Health Association Annual Conference, Cobo Hall, Detroit

Nov. 13 — Michigan Diabetes Association Symposium on Diabetes, Sinai Hospital, Detroit

Dec. 1-4 — AMA Clinical Convention, Miami Beach

Dec. 12-13-14 — 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing

Dec. 18 — The Council, MSMS Headquarters, East Lansing

Jan. 29 — The Council, MSMS Headquarters, East Lansing

Jan. 30 — State Woman's Auxiliary to MSMS, Board of Directors, MSMS Headquarters, East Lansing

Feb. 3-10 — Childrens Dental Health Week

March 12 — The Council, MSMS Headquarters, East Lansing

March 25-26 — Eighth Annual Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

May 21 — Annual Muscle Symposium, Wayne County Medical Auditorium, Detroit

TB SOCIETY PLANS CHRISTMAS SEAL SALE

Plans are being advanced by the Michigan Tuberculosis and Respiratory Disease Association for the 1968 Christmas Seal sale.

Association officers point out that most people associate Christmas Seals with the fight against tuberculosis, but many are unaware of the Christmas Seals' role in fighting other respiratory diseases such as emphysema, chronic bronchitis and asthma. In Michigan, emphysema deaths alone have risen from 228 in 1957 to 1045 in 1967.

In tuberculosis control much effort is placed in research, detection and education. Contributions also support the implementing of breathing exercise courses for asthmatic children and persons suffering from respiratory ailments, smoking education in our schools and smoking withdrawal clinics, and tuberculin skin testing and chest X-ray programs.

PROMOTED BY DOW

Charles W. Hinman, Ph.D., has been named by Dow Chemical Company to the newly-created position of assistant director of research for the life sciences. He has been with Dow since he received his doctorate in organic biochemistry from the University of Illinois in 1954.

26 Doctors Get MSMS Pins for 50 Years Service

Every year Michigan doctors who have completed 25 years of service receive a coveted pin before the House of Delegates.

This year, 26 Michigan physicians were eligible for the "50-year Service Pins." Nine were present to receive the Michigan award in person before the delegates. The other pins will be mailed.

The honorees included one past president — Edward F. Sladek, M.D., of Traverse City, and two former MSMS Council members — W. C. C. Cole, Sr., M.D., formerly of Detroit, and John T. P. Wickliffe, M.D., formerly of Calumet, both in California now.

The complete list of 50-year men are: Edward F. Sladek, M.D., Traverse City; Lloyd C. Harvie, M.D., Saginaw; M. S. Hurth, M.D., Ingham; W. B. Lewis, M.D., Battle Creek; Garnet G. Stonehouse, M.D., Grand Rapids; William V. VanderVoort, M.D., Hastings; Karm C. Kerwell, M.D., Stephenson; Alton R. Marsh, M.D., Dearborn; Sol M. Lewis, M.D., Ferndale; Joseph A. Kasper, M.D., Grosse Pointe Park; Elden C. Baumgarten, M.D., Grosse Pointe Woods; and Fred O. Lepley, M.D., Grosse Pointe Woods; Alfred H. Whittaker, M.D., Grosse Pointe; from Detroit — Clyde K. Hasley, M.D.; Arthur B. Norton, M.D.; Robert L. Novy, M.D.; Harold F. Raynor, M.D.; John B. Rieger, M.D.; Isaac S. Schembeck, M.D.; James M. Stanton, M.D.; Milton D. Vokes, M.D.; Ray S. Dixon, M.D.; William E. Hilton, M.D.; and also John T. P. Wickliffe, M.D., formerly of Calumet and now of Escondido, California; A. M. Giddings, M.D., formerly of Calhoun County, now of St. Mary's, Ohio; Wyman C. C. Cole, M.D., formerly of Detroit, now of Walnut Creek, California.

AMA Offers Folders About Drug Abuses

Because of the rising incidence of drug abuse in the United States, especially among young people, the American Medical Association has published five related pamphlets, "Amphetamines," "Barbiturates," "Marijuana," "LSD," and "Glue Sniffing."

Written originally for the 1968 Community Health Week program on drug abuse, the one-page pamphlets answer many of the questions frequently asked about this growing problem. In addition to describing the effects of these dangerous substances on the body, each pamphlet stresses the hazards of experimentation, the psychological effects on the users and the legal controls.

Review copies are available from the AMA's Department of Health Education. Quantity copies are available from Order Handling at 15 cents each; 50-99 copies, 14 cents each; 100-499 copies, 12 cents each; 500-999 copies, 10 cents each and 1,000 or more copies, 8 cents each.

CURRICULUM CHANGED

WSU Freshmen Get Introduction To Patient Care

A redesigned medical curriculum at Wayne State University went into effect on September 30. Ernest Gardner, M.D., dean of the School of Medicine, reports the 1968 entering freshmen, number 130, will be the first under the new program.

To the freshmen, the new curriculum means getting an introduction to problems involving patient care during the first year, rather than in the third year. They will study social and behavioral sciences, stressing the changing social and community roles of today's physicians. An integrated basic science curriculum in human biology will be taught by the departments of anatomy, biochemistry and physiology.

Dean Gardner said, "The new undergraduate program places emphasis on relating basic science knowledge to patient care. Flexibility through expanded electives will enable preparation for a variety of careers within the general divisions of private practice, academic medicine and research."

During their second year at the medical school, this year's freshmen will study physiology, pharmacology, pathology, microbiology, biostatistics, epidemiology, special topics in biochemistry and psychiatry, plus an intensive course in obtaining medical histories and performing physical examinations. Appreciation of medical history, culture and heritage will also be stressed.

Revision of the third year curriculum calls for clinical core courses in internal medicine and related specialties, surgery and related specialties, gynecology and obstetrics, pediatrics, psychiatry, and family and community medicine. Elective studies will make up the senior schedule.

Students who are now sophomores at the medical school will study phased-in portions of the new curriculum. Upper classmen will continue with much of the former program, laced with more relaxed policies on electives.

New House-Introduced Laws Bearing on Medicine Described

BY HERBERT MEHLER
OF THE MSMS STAFF

(Editor's Note: The September issue of **Michigan Medicine** described Senate bills which passed the 1968 Legislature and were given immediate effect. The following article briefly discusses House-introduced new laws which became effective upon being signed by the Governor. Subsequent articles will cover laws that become effective 90 days after adjournment of the Legislature on August 16, 1968. Copies of these laws are available by writing MSMS, 120 W. Saginaw, East Lansing 48823.)

Community Mental Health Services Law

Public Act 265 (House Bill 2294) amends Act 54, the Community Mental Health Services Act, so that the legality of a city-county board in Wayne County is no longer in question, and writes a new definition of eligible mental health programs more in keeping with the concept of comprehensive services. It provides that community clinics must come under the local mental health board by contract or direct administration within four years and gives the Director of the Department of Mental Health authority to extend this period for a reasonable time.

Amended is the Department's rule-making authority so that program priorities and minimum numbers and scope of services and activities of community mental health board programs may be prescribed by rule. Standards for professional personnel will be established by the State Department of Mental Health.

Repeal of the Criminal Sexual Psychopathic Act

Public Act 143 (House Bill 3387) repeals the 1939 law generally referred to as the "Goodrich Act." The legal category of criminal sexual psychopath is abolished. The remaining tools in our law for dealing with sexual offenders are as follows: the offender, if convicted of a crime, may be sentenced to prison; a provision of the Criminal Code adopted in 1952 provides that a sexual offender, if determined to be "sexually delinquent" as defined, may be sentenced to prison on a day-to-life basis or an indeterminate sentence, a statute which has been little used in the past; and under the Civil Commitment Act, a sex offender may be committed by the probate court if there is no criminal charge pending.

Clarification of Hospital Act

Public Act 125 (House Bill 3808) amends Section 9 of the Hospital Act for Mentally Diseased Persons to make clear that a peace officer, with the approval of the prosecuting attorney, may confine a mentally sick person in a hospital, home or other place of detention, not just a jail. Certification by two legally qualified physicians is required with temporary detention not exceeding five days unless the probate court shall be a special order enlarging the time. Persons manifesting homicidal or other dangerous tendencies can be confined in a jail or other lock-up facilities.

Also amended was Section 10 of the Hospital Act relating to qualifications of certifying physicians by eliminating the requirement that such physicians "must be permanent residents of the State."

Clarify Use of Sheltered Workshop Fees

Public Act 89 (House Bill 3643) allows a department hospital to retain fees collected in sheltered workshops operated by the hospital, and to use such funds to purchase supplies and equipment and to pay patients.

Licensing and Supervision of Clinical Laboratories

Public Act 235 (House Bill 2378) defines a clinical laboratory as a "facility which may be patronized by any physician, health officer or other person authorized by law for the purpose of obtaining information for the diagnosis, prevention or treatment of disease or the assessment of medical condition by examination of materials derived from the human body." This Act does not apply to laboratories operated by a person licensed or registered to practice medicine, who performs laboratory tests or procedures, personally or through his employees, solely as an adjunct to the treatment of his patients; of any college, university or school approved by the Department of Education which is conducted for the training of its students, if the results of any examination performed are not used in the diagnosis and treatment of disease; or those operated by the Federal Government.

The Director shall appoint a State Laboratory Facilities Council to assist with development of rules composed of three pathologists, one physician who is not a pathologist and is not directly associated with a clinical laboratory, two laboratory directors who are not physicians, one clinical chemist and one micro-biologist. The Director, with concurence of the council, shall promulgate, amend and rescind rules with reference to clinical laboratories.

Treatment and Rehabilitation of Alcoholics

Public Act 22 (House Bill 2961) defines alcoholism as a "chronic and progressive illness, characterized by an excessive and uncontrolled drinking of alcoholic beverages, and as a public health problem affecting the general welfare and economy of the state." The Act authorizes educational preventive programs for the treatment and rehabilitation of alcoholics; defines the duties of the Department of Public Health and establishes and defines powers and duties of a state advisory board of alcoholism.

The Act acknowledges the administrative transfer of the formally separate Board of Alcoholism through the principle Department of Public Health, as well as expanding the Advisory Council consisting of three licensed physicians one of whom shall be a qualified psychiatrist. The other four members represent the general public.

Sale and Possession of Certain Drugs

Public Act 126 (House Bill 3270) prescribes penalties for selling, offering for sale, bartering or otherwise disposing of or in possession of certain drugs, such as LSD, peyote, mescaline and its salts, DMT, silocyn, or psilocybin or any salt or derivative of the aforementioned or any drug possessing similar hallucinogenic properties.

Boards of County Institutions

Public Act 149 (House Bill 3467) permits counties with a population of less than 1,000,000 having an approved county tuberculosis hospital, the Board of Supervisors may create and appoint a board of county institutions for the purpose of maintaining and operating a county tuberculosis hospital, a county medical care facility and a county psychiatric facility; or may operate and administer all three as a single medical institution. Provisions also include authority to employ an executive head and other personnel and grants authority to the board for establishing policies covering operations of the hospital or institution, including the conditions of admission and the rates to be charged.

Regulates Narcotic Drugs

Public Act 86 (House Bill 3601) regulates and safeguards legitimate use of and traffic of narcotic drugs and exempt narcotic drugs; suppresses the illegitimate use, possession, control, sale, manufacture, production, disposition, administering, compounding, dispensing, prescribing and traffic by providing penalties for violations.

Public Act 103 (House Bill 3602) states: No prescription for any habit forming drug issued before or after the effective date of this Act may be filled or refilled more than six months after the date on which the prescription was issued and no such prescription which was authorized to be refilled may be refilled more than five times, except that any prescription for such a drug after six months after the date of issue or after being refilled five times may be renewed by the practitioner issuing it either in writing or orally if promptly reduced to writing and filed by the pharmacist filling it.

Appointment or Election of Medical Personnel to State Positions

Public Act 255 (House Bill 3776) provides that either a licensed medical physician or a licensed osteopathic physician is entitled to equal consideration, except on licensing boards, to appointment to governmental positions or service on state, county, city, township or other public agencies, departments or subsidiaries, wherever the laws of the state require such service.

VIEWPOINTS

Physician Must Help Detect Diabetes

BY HENRY D. KAINE, M.D., CHAIRMAN
DIABETES DETECTION COMMITTEE
MICHIGAN DIABETES ASSOCIATION

Diabetes Detection Week will be observed in Michigan and throughout the country November 17-23. The purpose of this intensified version of the year-round program to find the unknown diabetics and to test them, is to focus attention, with the help of the communications media, on diabetes and the need for early detection of diabetes.

In Michigan we are undertaking a program of free post-prandial blood sugar tests during Detection Week. Michigan hospitals have been asked to participate in this program. We are also asking the cooperation of the physicians of Michigan in this program. Helping to detect diabetes is one way of giving better medical care to more people. On the average, out of 122 patients who come into a physician's office, one will be an unknown diabetic. The earlier his diabetes is diagnosed and treated, the more successfully it will be controlled. MSMS members seeking additional information may write me at Michigan Diabetes Association, 6131 West Outer Drive, Detroit, 48235.

The importance of Detection Week was expressed by an editorial in the Journal of the American Medical Association for November 8, 1965: ". . . much work remains to be done. The drive stands in need of extension into areas where it has not yet penetrated. Toward that end Diabetes Week . . . needs the active participation of many more physicians. It would be a real service to patients, to the profession, and to the public if this year during Diabetes Week every physician in private practice would test for diabetes each of the patients he sees."

The Diabetes Detection Committee of the Michigan Diabetes Association urges physicians to do post-prandial blood sugar tests on their patients during Detection Week as a public service.

The Diabetes Detection Drive can succeed only with the cooperation of the practicing physician. He represents the first and main line of detection, as he is ultimately responsible for treatment. His help is essential if unknown diabetics are to be brought under medical care and thus remain effective members of the community.

Views Invited Re Drug Reports

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

A Drug Information Center has been established at the University of Michigan under a grant from the Michigan Association for Regional Medical Programs, Inc. to act as a rapid, random access service function to the medical professions of the state of Michigan. Its goal is to help bridge the gap between the medical professions and the estimated 200,000 articles of medical interest published per year as a meaningful and useful service.

The center is open 24 hours a day and may be reached by dialing 313 763-0243 or by writing the Drug Information Center, University Hospital E 3103, 1405 E. Ann Street, Ann Arbor, Michigan 48104.

The Drug Information Center received 30 requests in January and has progressed to 129 requests in July with a high of 146 requests in June.

Types of questions asked in July were: 1) Dosage - 26, 2) Therapeutic use - 13, 3) Side effects and/or contraindications - 1, 4) Availability - 26, 5) Adverse reactions - 4, 6) Therapeutic compatibility - 2, 7) Pharmaceutical compatibility - 10, 8) Identification - 27, 9) Toxicity - 3, 10) Metabolism - 1, and 11) other (stability, solubility, cost, etc.) - 16.

From these requests a good picture of some of the drug problems facing physicians should be available.

Your editors would like to establish a regular feature based on the information sought from the Drug Information Center. Such format might include lists of drugs and questions, "Drug Information Question of the Month" with in-depth discussion and answers or combinations.

Your editors would like to hear from readers as to their desires.

Be A Doer

Theodore Roosevelt, 26th president of the U.S. (1901-1909), emphasized the need for persons to try to improve politics rather than merely find fault:

"It is not the man who sits by his fireplace reading his evening paper and saying how bad our politics and politicians are who will ever do anything to save us; it is the man who goes out into the rough, hurly-burly of the caucus, the primary, the political meeting, and there faces his fellows on equal terms.

"The real service is not rendered by the critic who stands aloof from the contest, but by the man who enters it and bears his part as a man should."

What Are The Reasons?

FROM THE NEBRASKA
MEDICAL SOCIETY JOURNAL

Some 14,000 students became finalists in the National Merit Scholarship program, and 10,770 of them chose their careers.

Seven percent of them, or 767, want to be doctors.

Only 767 out of 14 thousand?

Last year, eight percent, or 950, chose medicine.

The decline may seem like only one percent, *but it isn't*. When you go from *eight* of anything to *seven,* you've dropped one part in eight, and that's twelve and a half percent.

From 950 to 767 is a big drop. To bring home this point more forcibly, a fall from 950 to 767 is a decrease of 19.2%. To make it even stronger, the year-ago number was 23.9% larger than this year's.

We seem to be declining in quantity and, if we may say so, in quality.

It is easy, much too easy, to conclude that things are just fine, that the top students are still entering medicine.

But they're not. Just look at the figures.

Last year's total was higher than the one for 1965-1966. And guess what happened in 1966. Oil companies discharged geologists after the Suez crisis, and geology enrollment fell sharply. And if after 1966, fewer top students want to be doctors, our politicians should be told, and they should be told why.

More schools may give us more students, and we are not at all sure of this, but they won't give us better ones. The better ones aren't interested, not like they used to be.

We can only hope that the government will look at these figures and think, and call a halt to the socializing of medicine, and make the practime of medicine inviting.

The way it used to be.

Let's Take The Lead

FROM NEVADA STATE
MEDICAL SOCIETY JOURNAL

In no area of human activity is the folly of trying to reach a desirable goal by merely writing laws and spending tax funds more apparent than in the field of health care. Acting Health, Education and Welfare Secretary Wilbur Cohen, an outspoken welfare advocate, recognized this when he questioned the feasibility of expanding Medicare at this time. Although a staunch supporter of more government in medicine, he said such action would be "to precipitate." He told news reporters that shortage of hospital beds and physicians are problems that need solving first.

The medical profession is taking the lead in helping to solve these problems. Through its spokesman, the American Medical Association, the profession has called for all medical schools to "accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted." It also supports federal participation in medical school construction to encourage applicants to be admitted. It also supports federal participation in medical school construction to encourage a greater production of physicians.

The president of the American Medical Association expressed the attitude of his colleagues when he commented, "Medicine has not failed the nation. Granting the existence of problems, we have today a firm base of widespread excellence upon which to construct the additional improvements which all of us recognize are needed."

The quickest way to destroy high medical standards would be to treat doctors as if they were public property, and to swamp their good works in an orgy of government medicine.

Going to Miami?

BY JOHN W. MOSES, M.D.
SCIENTIFIC EDITOR

The American Medical Association conducts two national meetings a year, the Annual convention and the Clinical convention. The 22nd Clinical Convention will be held in Miami, Florida, December 1-4, 1968. The Clinical Convention is beamed to the busy practitioner and attempts to inform the physician of the latest advances in medical knowledge and technology.

During this year's Clinical Convention there will be 125 exhibits reflecting the latest developments in pharmaceuticals, medical equipment, and scientific endeavors. There will also be special postgraduate courses in diabetes, fluid and electrolyte balance and thyroid disease. About thirty medical motion pictures and live color scientific television programs will be offered. Clinical workshops and four breakfast roundtables will complete the program.

In these days when scientific progress is advancing so rapidly, the 22nd Clinical Convention offers a rapid and enjoyable way of keeping abreast of the latest developments.

Give your wife a day in the sun while you increase your knowledge.

See you in Miami.

MASON, HUFF CHOSEN AS CO-CHAIRMEN

Michigan Leaders Endorse MSMS Proposed Citizens Committee on Medical Manpower

A Michigan Citizens Committee on Medical Manpower was called for October 16 to spearhead a statewide effort "to produce more doctors of medicine and other medical personnel in Michigan to help relieve critical shortages in many Michigan communities."

The need for a Citizens Committee was discussed by a group of distinguished medical, educational, business, and labor leaders called into session in Detroit by MSMS.

After a unanimous agreement to organize a citizens-committee movement, the group elected Robert J. Mason, M.D., MSMS President Elect, and Warren M. Huff, of Plymouth, long-time prominent leader in Michigan educational and civic affairs, as co-chairmen.

* * *

THE CITIZENS COMMITTEE when formed will include prominent leaders in the field of business, industry, government, labor, agriculture, education, and community service. Regional committees are to be organized on a similar pattern.

The ad hoc citizens group agreed today to accept the evaluation of MSMS House of Delegates that "the quickest, most economical and most effective way to produce more physicians in Michigan is to immediately expand the present two-year medical school at Michigan State University into a four-year, degree-granting medical college."

The MSMS House of Delegates, at its recent annual meeting, instructed that "citizen groups should be established which would take it upon themselves to join the physicians in urging the necessary legislative financial support to meet the demands for more physicians."

* * *

THE HOUSE OF DELEGATES declared that "through the development of the clinical areas of the Michigan State University College of Human Medicine, the State of Michigan can most immediately, effectively and economically qualify the present MSU program as a fully-accredited medical school, and thus with speed and efficiency increase the supply of well-trained physicians so greatly needed to meet the health needs of our rapidly growing population."

Many statistics point up the need to train more physicians in Michigan, declares Robert J. Mason, M.D., Birmingham, MSMS President-Elect, who chairmaned the conference. He said the medical schools at the University of Michigan and Wayne State University graduated 307 physicians this June, leaving Michigan far below the output of many other states. This condition will still hold true if Wayne State and the University of Michigan medical schools expand to their maximums planned — as was also advocated.

MSMS President-Elect Robert J. Mason, M.D., presided at the organizational meeting of the Michigan Citizens Committee on Medical Manpower.

* * *

MEANWHILE THE demand for physicians continues to rise each year in Michigan and the nation, Doctor Mason said. There is a current shortage of an estimated 52,000 physicians in the nation today.

MSU admitted its first class of 26 freshman medical students in 1966 and then added 26 more in 1967 and 26 more this year. The Michigan State Board of Education approved the detailed plans submitted by MSU in 1967 for a degree-granting program.

* * *

THE SECOND EVENT in the new medical manpower appeal was the Conference on Michigan Medical Manpower at the MEA conference center October 23 for physicians, school counselors, college officials, hospital administrators, government representatives, health agency executives, and others concerned with education and medical care. Doctor Mason was the banquet speaker, again stressing the need for a broad citizens effort to help convince the governor and the legislature to move forward the MSU proposal and to plan for the future.

Robert E. Rice, M.D., Greenville, was chairman for the conference.

More details will appear in the November *Michigan Medicine News Extra.*

Five Receive MSMS Certificates

Five Michigan physicians were voted the coveted "Certificates of Commendation" by the 1968 House of Delegates.

In making the report for the House Committee on Certificates of Commendation, Chairman Marjorie Peebles Meyers, M.D., declared:

"The Committee is proud to present for the consideration of the 1968 House of Delegates the names of five distinguished Michigan doctors of medicine for Certificates of Commendation. They are alphabetically, A. Fleming Barbour, M.D., Genesee; Harry A. Clark, M.D., Mason; John M. Dorsey, M.D., Wayne; Fred C. Sabin, M.D., Marquette; and Wilbur D. Towsley, M.D., Midland. Each was nominated by his county medical society, and was considered by the Committee along with other county nominations."

The House concurred.

All were present to receive their awards at the Delegtaes Dinner except Doctor Towsley, whose health did not permit him to travel from Midland. Harry A. Towsley, M.D., a Washtenaw delegate, accepted for his brother. Harry received such a citation himself in 1966.

* * *

Doctor Barbour who has practiced in Flint for 28 years, received a citation which declared:

"In recognition of his inspiring civic service in Flint for more than 25 years, especially with community programs for children, churches, the needy; and also for his excellent leadership in medical and specialty organizations."

Fleming A. Barbour, M.D., right, Flint, who received a Certificate of Commendation, visits with Harry A. Towsley, M.D., left, Ann Arbor, who accepted the Certificate for his brother, Wilbur D. Towsley, M. D., of Midland, who was unable to attend the Delegates Dinner.

* * *

Doctor Clark, who taught medicine from 1919 to 1949 and since has practiced at Muskegon, Ludington and Scottville, received a citation which stated:

"In recognition of many years of inspirational teaching as a professor at the Wayne State Uni-

A Certificate of Commendation was received by John M. Dorsey, M.D., right, distinguished WSU professor, from Speaker James B. Blodgett, M.D., at the Delegates Dinner.

Harry L. Clark, M.D., right, Ludington, received a coveted Certificate of Commendation from Speaker James B. Blodgett, M.D., during the Delegates Dinner.

Continued: Five Certificates

versity Medical School; and in appreciation for continuing medical contributions to the people of Muskegon, and now Mason counties."

* * *

A member of the WSU medical faculty since 1946, Doctor Dorsey received a certificate which read:

"In recognition of his distinguished career as a psychiatrist, teacher and chairman of the Wayne State University Medical School Department of Psychiatry; and his many continuing contributions now to medicine, literature and education as the 'WSU University Professor.' "

* * *

Doctor Sabin, who has practiced at Marquette since 1957, accepted a citation which declared:

"In recognition of his dedicated service as a member of the Northern Michigan University Board of Control and as a member of the Michigan State Board of Registration in Medicine; and as a prominent citizen of Marquette in professional, political, and business circles."

* * *

The citation for Doctor Towsley, who has practiced in Midland for 45 years, read:

"In recognition of 45 years of distinguished service in Midland as a beloved family doctor; and for his unselfish assistance to many medical students, and also to many children and families in need."

Since the Certificates of Commendation were established in 1961, the House has approved four awards in 1962, four in 1963, six in 1964, three in 1965, seven in 1966, and six in 1967.

Fred C. Sabin, M.D., Marquette, received a Certificate of Commendation from Speaker James B. Blodgett, M.D., during the Delegates Dinner.

U-M Med School Tells Changes In Key Posts

Several changes have been made in the administrative staff of the University of Michigan Medical School this fall.

John A. Gronvall, M.D., has been named associate dean to succeed Alexander Barry, M.D., who joined the University of California School of Human Medicine at Davis. Doctor Gronvall had been associate dean and associate director of the University of Mississippi Medical Center.

Robert A. Green, M.D., who has served as assistant dean part time the past year, was appointed to the new position of associate dean for student affairs. The new office of associate dean for academic affairs has been filled by George R. DeMuth, M.D.

Doctor Gronvall currently is director of a national curriculum study sponsored by the Association of American Medical Colleges. He has been closely involved with the development of U.S. regional medical programs. In 1966, Doctor Gronvall was acting dean of the Mississippi School of Medicine and acting director of the Medical Center. A pathologist, he is a graduate of the University of Minnesota.

Doctor Green has been a U-M faculty member since 1958. In his new position he is responsible for liaison activities with schools, colleges, and hospitals; for the review of applications for admission; for counseling; for discipline; and for keeping tabs on the academic and professional development of each of the nearly 800 students on the nation's largest medical campus. Doctor Green has coordinated the special studies program of the Medical School and also is chief of the pulmonary disease section of Ann Arbor Veterans Hospital.

Dean William N. Hubbard, Jr., M.D., explains that the establishment of the office of associate dean for academic affairs reflects the urgent need to revise medical education to respond to new social needs. In that post Doctor DeMuth is responsible for revising the curriculum and promoting research in medical education.

Doctor DeMuth, a pediatrician specializing in pulmonary disorders, has been at U-M since 1956. He has been involved with faculty committees concerned with curriculum, examinations, research, and general educational policies the last five years. He is chairman of the faculty conference on curriculum, and a member of the clinical planning committee responsible for a major part of the new Medical School curriculum.

Ross V. Taylor, M.D., right, of Jackson, and Ralph R. Cooper, M.D., Detroit, are the new leaders for The MSMS Council for 1968-69, elected at the re-organizational meeting at the close of the 1968 Annual Session. Doctor Taylor was advanced from the vice-chairmanship to serve as chairman, and Doctor Cooper was chosen as the new vice-chairman. Doctor Taylor succeeds Robert J. Mason, M.D., who was named by the MSMS House of Delegates as the new President-Elect.

Elect 10 MDs To Shield Board

Ten physicians were among those elected at the 1968 Michigan Blue Shield Corporation meeting to the Shield Board of Directors.

The physicians elected to the board were Brock E. Brush, M.D., Detroit; Eugene L. Freitas, M.D., Detroit; Harold Gehring, M.D., Royal Oak; Homer A. Howes. M.D., Detroit; Philip J. Huber, M.D., Detroit; William B. Jensen, M.D., Grand Rapids; Paul T. Lahti, M.D., Royal Oak; Julien Priver, M.D., Detroit; George L. Reno, M.D., Detroit; Richard E. Wunsch, M.D., Traverse City.

Also elected were Kenneth Boekeloo, Detroit; Laurence A. Hill, Ann Arbor; Frank J. McDevitt, D.O., Livonia; Kenneth Wolz, Saginaw; Victor M. Zink, Detroit.

Elizabeth Crosby, M.D., right, who numbers her medical students in the thousands, was honored by the University of Michigan Medical Center Alumni Society this month for outstanding service. John Goodsell, M.D., Saginaw, president of the Alumni Society, presented the certificate to Doctor Crosby. Also saluted was Mrs. Dolores White, center, long-time assistant head nurse at University Hospital.

Vernon V. Bass, M.D., left, Saginaw, Chairman of MDPAC, visits with the two congressmen-speakers after the annual MDPAC Breakfast. Congressman Donald Riegle serves the 7th Congressional District of Genesee and Lapeer counties, and Congressman John Conyers, Jr., serves the 1st Congressional District, covering a portion of Detroit and all of Highland Park.

Kellogg Fund Finances More Studies By State Board about Health Care

A grant of nearly $100,000 was made recently to the Michigan State Board of Education by the W. K. Kellogg Foundation of Battle Creek to help finance studies of educational programs in medical and allied health fields.

The money, which totals $98,680, will be used to continue the work of the State Board Advisory Committee on Education for Health Care.

State Board of Education President Edwin L. Novak of Flint said the grant will be used to subsidize salaries of the committee's staff for two years, providing for a project director and assistant, two researchers and staff travel as well as office equipment and supplies.

"We are indeed pleased that the Foundation in recognizing the important work of this committee has given so generously to support its efforts," Novak said.

THE 17-MEMBER COMMITTEE was organized in April, 1966, and charged with studying educational implications of health manpower needs in Michigan and making recommendations to the Board concerning educational preparation of such manpower.

It hopes to accomplish its goals in a three-phase program:

1. An inventory of health care manpower in Michigan, including an inventory of the educational programs for the preparation of such manpower;
2. Development of a plan to provide educational facilities and programs necessary to meet the needs for health care personnel in Michigan;
3. Further studies and research which relate to findings and recommendations of Phase I and II.

Three advisory groups report directly to the Citizens Committee. The first, called the General Advisory Committee, is charged with taking a "functional approach" to health manpower needs, and is staffed on the basis of individual qualifications of members, rather than professional or institutional affiliations.

THE OTHER TWO subcommittees report directly to the General Advisory Committee. The Advisory Committee on Medical Education is composed of medical doctors and osteopaths, and the Advisory Committee on Nursing Education is represented by professionals in the field of nursing. Both subcommittees provide technical assistance and data from their respective areas and recommend programs to fill manpower shortages.

These recommendations are then included with other reports compiled in related health fields and submitted to the Citizens Committee. Before being submitted to the State Board of Education, the reports are reviewed by the Citizens Committee and evaluated in terms of cost, compatability, political implications, etc.

The flow may also be reversed. When an institution of higher education requests sanction from the State Board for establishing academic programs in health-related vocations, the Board often asks for study and recommendations by the Citizens Committee before taking action.

A COMMITTEE STUDY of schools of medicine in the state led to the recommendation of a four-year School of Medicine at Michigan State University. The committee has also made significant recommendations on the needs of osteopathic medicine in the state and has set up a system of priorities for new medical schools. It is currently studying a proposal to establish a College of Osteopathy in Michigan.

The Committee conducted a survey of applicants and admissions to associate degree nursing programs and has worked closely with many health-oriented agencies and organizations, such as the Michigan Association for Regional Medical Programs, the Comprehensive Health Planning Commission, the Manpower Task Force of the Vocational Rehabilitation Comprehensive State Planning Project, the Human Services Occupations in the Department of Mental Health, and others.

It is currently compiling the final report of Phase I, which surveyed the supply and distribution of manpower in a wide variety of health professions and occupations as well as the education programs for the preparation of such health personnel. Preliminary findings and recommendations are divided into two areas: (1) general recommendations relating to the need for trained manpower in a wide gamut of health careers, the need for continuing planning and coordination to meet these needs, means for implementing such planning, and the role of the institutions of higher education in meeting the needs for trained manpower in health fields; and (2) specific recommendations relating to particular occupational areas, e.g. medicine, dentistry, nursing, medical laboratory services, etc.

ALTHOUGH ADDITIONAL recommendations and slight alterations may occur in the final draft, the preliminary report includes the following conclusions:

1. Primary responsibility for the development and administration of educational programs in the health care area should be carried by educational institutions.
2. Where clinical experience is an integral part of education for a health profession or occupation, such experience should be under the control of the responsible educational institution. The health facility providing such clinical experience should be reimbursed for such educational costs as instructors' salaries, stipends, teaching materials, etc.
3. Preparation of qualified faculty must take high priority in the development of educational programs in the health area. Shortages of competent faculty in many teaching areas emphasize the need for careful planning for expansion of existing programs and establishment of new programs to ensure the most effective use of faculty resources.
4. The impact of new knowledge and technology in the health care field will require innovations in curricula of programs preparing health personnel. It is particularly important in setting up new educational programs that sufficient flexibility be built in to take account of anticipated changes in the role of the particular health profession or occupation.
5. The university medical centers should assume a leadership role in the development of educational programs in the health area in the dissemination of research findings and in the continuing education of health personnel. These efforts should be coordinated through the Michigan Association for Regional Medical Programs.
6. Universities with medical centers or with considerable strength in the biological and physical sciences should consider developing interdisciplinary programs in the preparation of allied health personnel. Such Schools of Allied Health Professions have already been established in a number of states.
7. Reciprocity between community college districts is needed to implement regional planning for education of allied health personnel.

IN ADDITION TO working on a state plan for adequate health care education facilities, the Committee in the next two years will help develop demonstration projects in allied health education such as medical technology and para-professional fields.

Other areas of Committee concern may be establishment of a statewide health manpower data bank, the licensure and registration of health professionals, the development of a core curriculum in health sciences for community colleges and new curricula for evolving health technologies.

The Committee also will consider recruitment programs to interest young people in the health professions and to reactivate existing trained personnel who have left health careers.

AMA Invites You . .

MSMS members, when they are in Chicago, are cordially invited to visit the AMA Headquarters at 535 N. Dearborn.

Last year, nearly 900 persons toured the AMA building. The AMA extends a warm welcome to all physicians, their wives and guests to take a 40-minute tour to become better acquainted with the AMA's organizational structure, its major areas of activity and some of the numerous services available to physicians, as well as the public. Tours are given between 9:00 a.m. and 4:00 p.m., Monday through Friday.

Doctor, Your Shield Is Showing

BY LELAND E. HOLLY, II, M.D.
MUSKEGON

It appears appropriate that the record and future of Michigan Blue Shield should be reviewed. Certain of the specific observations and associated criticisms that have in the past been very pertinent can now stand only as matters of record. As such, however, they may be important at the next point in time when a review is again seen to be desirable. That time will come.

Blue Shield: The Doctors' Plan?

All advertisements say it is. The Michigan State Medical Society started Blue Shield in 1931. Further, the doctors of Michigan even reduced fees in the 1940's to "save" the plan from bankruptcy.

Blue Shield inception and growth has always been directed by the Blue Shield Board of Directors. Physicians have always been in the majority on this board. While this representation does not in any way indicate that Blue Shield direction was or is given by a concurrence of the majority of the physician directors, it has cemented the idea of a "doctors' plan" in the thoughts of the public.

The M-75 plan, with fee level tied to income classification, was touted as representing the physician's classic approach to charging fees, and was given near unanimous support by the Michigan State Medical Society.

In 1966 the Michigan State Medical Society changed tacks, and in resolution No. 29 the House of Delegates provided for establishment of the concept of reasonable, customary and prevailing fees. Again, we have a "doctors' plan."

If there is still doubt in your mind, answer the question, "Who will be blamed if Blue Shield fails?"

Blue Shield Views Itself

In 1931 Blue Shield was born in Battle Creek in a time of great economic deprivation. It was a time of great public and professional need and Blue Shield played the role of guardian savior to lay and professional alike.

President McCabe recently described the purposes at that time, ". . . Blue Shield would not be a commercial enterprise, an 'economic undertaking,' but would be a means of service alone, with free choice of physician, with limitation of benefits to service, with exclusion of profit."[1] President McCabe went on to say that the first plan offered would provide, ". . . in effect, comprehensive full prepaid medical care in home, in the physician's office, in hospital."[1]

In 1968, at a time when public and professional needs may be of greatly different character than in 1931, President McCabe said of the early ideals, "The goal was right. The know-how was not."[1] "It seems to me," said Mr. McCabe, "that this can be crystallized very simply to provide a mechanism substantially which sustains and maintains the desirable elements of the private practice of medicine in such a way as to make available quality care at the lowest possible cost."[1] Mr. McCabe also states, "Blue Shield must be the answer."[1]

Blue Shield as a "Savior"

There is good reason that Blue Shield would have doctors continue to believe in its role as the guardian and savior of medicine and the public. Physicians should remember, however, that a bankrupt Blue Shield and the public were "saved" by medicine in the fee-cutting days of the 1940's, and that a dying Blue Shield is again being rescued by physicians' approval of the Michigan Variable Fee. To accept both the thought of being "saved" and "saving," physicians are led logically and inescapably to the conclusion that they have been and are saving themselves and the public with their plan.

James E. Appel, M.D., of the AMA can be quoted, third hand, as follows: "The voluntary establishment of reasonable income ceilings is the only protection the profession has against governmental price controls."[1] While financial woes were the danger in the past, the new threat is government control. Physicians again find themselves preparing to "save" themselves and the public.

In this confusion doctors lose sight of the fact that Blue Shield is for all effective purposes a totally separate entity and could be totally independent of organized medicine. Consider, for example, its third-party role in Medicare.

Blue Shield and Quality Care

The main thread of the Blue Shield idea is to make quality care available at the lowest possible cost. It must be presumed that Blue Shield refers to **high** quality care. Consideration of the cost aspect can be postponed for the moment.

Unclear is how Blue Shield is to insure the height of the quality. Our state medical society has the means to control the quality of medical care and, in fact, does exercise the controls without regard to Blue Shield or any other insurance, governmental or lay program. The guarantee of high quality medical care is our moral and ethical obligation, and our right alone. It is not a right we have delegated to any lay party. Or have we?

Direct and indirect controls must be exercised in order to guarantee the patient his service and the doctor his fee. To the public "participators" are "good guys" and "non-participators" are "bad guys," and, somehow, the stamp of "quality care" is attached to the services of the former. Blue Shield emerges as the "protector" of the innocent sheep among the wolves.

Blue Shield and the Elimination of Profit

That the Blue Shield insurance **business** should make medical care available at the lowest possible cost and not make a "profit" has been clear from its beginning, but Mr. McCabe says "Doctors must pass on to the patients some of the savings resulting from increased productivity, especially **as the amount of free service diminishes.**"[1]

Just what percentage of billings turns out to be "free service" in the physicians' experience? Does this percentage of "free service" apply to all doctors or to just a few? How much of the "free service" is reduced by the Blue Shield program? Is the number of "free patients" cared for by most doctors sufficient to make any difference in physicians' charges to other patients? Regardless, since 1957 it appears Blue Shield has extended the concept of no "profit" to physicians' fees.

Every physician must determine this for himself since what may be true for one physician or in one area may not be universally true. The fact remains, however, that the Blue Shield program between 1957 and 1968 went beyond the concept of a non-profit **business** venture when it passed on "savings" to patients by restricting professional fees to a level which it, in effect, had determined.

Blue Shield and Two Fee Schedules

Through the years under the cover of M-75, "the doctors' plan," this unreasonable Blue Shield fee restricting activity has made a double fee schedule necessary for many "participating" physicians. It has meant non-participation for many more. These physicians came to feel that the favorable premium rate Blue Shield subscribers enjoyed, supposedly generated from an effective, efficient, non-profit insurance system, was simply a reflection of the inadequate fees allowed. Some physicians have suggested that the unique and onerous clerical requirements of the Blue Shield program should actually justify a surcharge.

On the other hand, the existence of such a double fee schedule for "participating" physicians and non-participation by many others has been construed by some patients and public to mean that the **honest** fees of these physicians are **prima facie** evidence that they have "profited" off private-pay patients and unfavored insurance companies. This certainly is a logical deduction when it has long been and continues to be Blue Shield's assumed duty to determine a physician's "valid"[1] fee and its "normal evolution."[1] After all, it is the doctors' plan, isn't it?

It has been said that the existence of inequitable fees is not Blue Shield's doing, and that other factors and people have been involved since 1957. Is it just the insurance commissioner, or were other identifiable influences also at work? If the cost of living rose 20 per cent by 1971 could physicians' fees be changed accordingly?

The desirable elements of the private practice of medicine seem to include the preservation of the right of the physician to set his own high

LELAND HOLLY, II, M.D.

The author is in practice as a radiologist; 889 Second Street, Muskegon 49400.

standards of care and also his own fair fee. If physicians have given up any part or all of these rights, directly or indirectly, they should know clearly why, the extent, and to whom. Given up they are, but the terms are unclear to most physicians.

Blue Shield Keeps Fees Down

To the extent that the extra clerical work Blue Shield requires is done in every doctor's office and hospital at no expense to Blue Shield and to the extent Blue Shield benefits are less than a physician's honest compensation, medical costs are held down.

Mr. McCabe has seemingly ignored other factors when he said, "Consider non-participation from an impersonal point of view. I have no doubt that should non-participation be large there will be inevitable and rapid escalation of fees, for such is the nature of economic pressures, no matter how high may be our resolves."[1]

Certainly, Blue Shield should recognize that economic pressures are a valid reason for raising fees. Blue Shield certainly should also recognize that 95 per cent of the physicians are conscientious, honest, reasonable, cooperative, and, believe-it-or-not, sensitive to patients' and Blue Shield's problems with bills. Or isn't physicians' economic welfare important? Or aren't 95 per cent of physicians honest?

That there would be a "rapid escalation of fees" is an assumption on the part of Mr. McCabe which may or may not be true. Historically, it certainly has not been and some examples quoted from an actual fee schedule of several years ago, compared to those more current will lend credence to an opposite viewpoint.

1934 - Ordinary day visit (7 a.m.-10 p.m.) [away from office]	$3.00-$5.00[2]
1959 - 003 Home, First Visit	$7.50[3]
005 Hospital, First Visit	$10.00
Subsequent Visits	$4.00
1967 - 9001 & 9009 Routine limited visit at home	$12.50[4]
1967 - 9601 Initial Hospital Visit	$15.00[4]
Each day for 20 days thereafter	$5.00
1934 - Appendectomy	$125.00-$250.00[2]
1959 - 3261 Appendectomy	$105.00[3]
1967 - 3261 Appendectomy	$175.00[4]
1934 - Chest - Heart	$10.00[2]
1959 - 7100 Chest, PA	$10.00[3]
1967 - 7100 Chest, PA	$10.00[4]
1934 - Pyelogram, Intravenous	$15.00-$20.00[2]
1959 - 7372 - Pyelography, Intravenous	$30.00[3]
1967 - 7372 - Urography, Excretory	$35.00[4]
1934 - Wrist x-ray	$5.00[2]
1959 - 7256 - Wrist	$10.00[3]
1967 - 7257 - Wrist	$10.00[4]
1934 - Cystoscopy, Hospital	$25.00-$50.00[2]
1959 - 3931 - Cystoscopy, Diagnostic, initial	$15.00[3]
1967 - 3931 - Cystoscopy, Diagnostic, initial, hospital	$50.00[4]

These examples, admittedly not comprehensive, indicate a very strong tendency on the part of physicians to hold fees down and to pass on the rewards of increased productivity to the patient. Where increases seem large is where overhead expenses such as wages, equipment and rental rates are greatest (up to 70 per cent), or where the service is not comparable.

Is credit for this remarkable record to be assumed by Blue Shield?

Blue Shield Recognizing Its Ills

Of M-75, a program that was hoped would cure Blue Shield's problems, Mr. McCabe has said, ". . . as you and your patients become increasingly irked by these fixed-fee levels and patient income classifications, by such things as slow recognition of specialities, by all the signs of what you might call obsolescense of what you and Michigan Blue Shield had devised, medicine and Shield went back to that original search for common effort for common cause."[1]

A great majority of Michigan State Medical Society physicians were willing to admit many years ago that M-75 had been a mistake, but the clamor that arose for correction got no response for those many years. It does not appear, therefore, that 11 years of progressive deterioration came about because the doctors wanted it that way. It appears that the major culprit may be hopefully seeking someone to share the burden of guilt.

It is probably fair to say that Blue Shield inertia has been caused in part by the Michigan State Medical Society's failure to direct and insist upon coherent, in-depth studies of, and solutions for, current and future socio-economic and health needs. Nor has the Michigan State Medical Society demanded clear correlation between Blue Shield's words and deeds. As an example, it is only necessary for physicians to consider the following statement of Mr. McCabe, "As I have said, we do not intend to force doctors to spend their time shuffling paper. Your business is rendering medical care."[1] Or a physician can consider another quote from Mr. McCabe, "May I quickly add that I believe that your experience with Blue Shield in present review procedures, both in connection with this and in the matter of determination of reasonableness of fee, mentionad a few minutes ago, has shown you that we at Michigan Blue Shield have and intend to continue to cooperate fully with the profession in such matters."[1] Some physicians would be rather definite in stating that for 11 years considerable paper shuffling has continued unabated, perhaps even enhanced, along with growing uncooperation and unresponsiveness on the part of Blue Shield.

Apparent acceptance over the years of the Blue Shield program in southeastern Michigan, without suggesting that this acceptance is not based on the informed desire of area physicians, has played a tremendous role in justifying the continuation of Blue Shield and the apparent inertia of its dynamic growth and maturation over the last ten years.

A Recommendation to Blue Shield

From a truly doctors' insurance program, as Blue Shield professes to be, physicians should not expect:

1. Immediate changes in policy after such have been recommended by physicians.
2. A program which ignores individual physician dishonesty or fails to have a means to guard against it.
3. A program to pay "way out" charges without realistic examination.
4. A program which will respond to vituperative, stubborn, disinterested, selfish, nonconstructive non-cooperation.

But doctors should expect to enjoy:

1. As great a simplification of billing as modern technology can provide.
2. Development of an effective, efficient system for redress for all parties in the insurance program.
3. An effective system for constant program modification as economy and medical advance dictate.
4. A current fair and reasonable variable fee adjusted each year or at similar reasonable intervals.
5. Prompt, essentially unquestioning payment for services.
6. A favorable image presented for all physicians, regardless of whether they are "participating" or not.
7. Fair, friendly, and tactful dealing with physicians without threats of harassment.

In return physicians should provide:

1. Proper identification of the service.
2. A record for the reason for the service.
3. A reasonable charge for the service determined by good practice under the circumstances.
4. Complete identification of the recipient of the service.
5. Availability of record for confidential and actuarial use of the carrier and for surveys to determine veracity of providers and consumers.

Blue Shield Curing Its Ills

Blue Shield has come up with its new Michigan Variable Fee program (MVF). This new program is said to guarantee a physician his usual and customary charge providing it is reasonable. Mr. McCabe asks, "Realistically, who can object? There are adequate provisions for payment outside range for unusual circumstances and procedures."[1] Such a promise for the variable fee program seems to fly in the face of past experience.

Mr. McCabe says, further, "As I see it, it is a simple question of working cooperatively and positively together in the development of the techniques needed to reach a common cause."[1] All physicians must agree with this but they must also note that if the doing is as simple as the asking, and if there had been a lot more of the former, the grand promise of reaching the "common cause" might have more substance.

As to the promise of the physician's reasonable and customary fee, the words are nice, but the promise may be empty when analyzed. "Profiles" or "prevailing fees" can have no meaning from Blue Shield experience to date since there has been no adequate, modern, complete standardized reporting of services in the absence of a common coding and nomenclature system.

Among other things the "prevailing range" of the new Michigan Variable Fee program is dependent upon community size and area in the state according to "exact differences in such fee determinants in the past."[1] In the absence of a uniform state-wide reporting system, presuming no other deficiencies in the statistical data of Blue Shield, the existence of such exact determinants is open to serious question.

A customary fee may be altered on 90-day notice. "Action will be immediate."[1] Even though the request be denied as being outside of the prevailing range, the factor of a request for alteration ". . . itself will tend to extend the prevailing range, in standard statistical method."[1] Historically, "immediate" is subject to wide interpretation by Blue Shield. And just how the standard statistical method operates in the Blue Shield situation is obscure.

Do physicians have clear knowledge of how they can alter their fees; can they have clear expectations that this alteration will be accepted? Can a raise in fees above the fair and reasonable fee for 1968, as determined by Blue Shield, both as to amount and timing, ever be accomplished without approval of big industry-labor, the insurance commissioner or others?

To date the new MVF program has been woefully inadequate in meeting effectively, much less efficiently, many of the requirements of any reasonable insurance program.

Who's in Control?

Given the Blue Shield program, doctor control is of paramount importance, but it is not attainable through the Blue Shield Board of Directors, nor with any certainty through the House of Delegates as the Blue Shield corporate body. In those two groups there is only doctor **influence.** Any absolute control is diluted by the many outside forces which are usually non-medical.

Unless doctors act as a nearly unanimous group of non-participating, non-assignment-taking providers, or act on nearly unanimous recommendation for dissolution by the House of Delegates of the Michigan State Medical Society as the Blue Shield Corporation, the Blue Shield insurance program will continue to function with doctors' control greatly diluted. There does not appear to be a middle road.

There is very real and justified confusion as to whom the Blue Shield creature belongs — big industry-labor or the Michigan State Medical Society. We know to whom everyone thinks it belongs, and at whose feet blame for difficulties will be laid. But Blue Shield fees and service benefits are tied to industry-labor negotiations with no guarantees of acceptable adjustments as they may be desired by the medical profession. There is only an unspecified promise, unbacked by past performance, of a dynamic insurance program which will keep pace with the times medically and economically. Can physicians believe this is possible if the real control lies with industry-labor or some other faceless group?

We are asked to accept this promise only because Blue Shield needs us. But what have they shown to warrant such trust? For ten years the Blue Shield program has been extremely unresponsive to the needs of the medical profession. It is not practical for physicians to accept another ten years of the same, or, for that matter, even three years.

Such inability of Blue Shield to respond particularly to unique or varying provider situations, unless the provider has been of the stature of large institutions not generally found in out-state Michigan, should be a matter of great concern. The signature of approval on the participation agreement of the individual "little man" physician working for his patients by himself is certainly very trusting. It is questionable if his consent to "participate" is informed.

The dilemma of the individual physician who wishes to practice non-participation is pointed up by the implication of Mr. McCabe's words when he states, "I am afraid it [per case participation] may successfully deter full participation and will be looked upon by those in our community who we must also satisfy — those who pay the bill — as an indication that the medical profession is unwilling to be cooperative, is unwilling to even subject itself to the administrative jurisdiction of an organization in which it plays a major role — in fact, the significant policy-making role."[1] It appears clearly implied that the independent physician may be considered some form of pariah if he does not cooperate.

Doctor Approval Is an Act of Faith

It appears quite definite that most Michigan physicians signed the agreement to participate in the Blue Shield Variable Fee program. If this were not the case, it cannot be conceived that large corporations would purchase this kind of insurance for their employees. It is also certain that the management group, as well as the employees, expect that the employee will not have to pay a cent for any medical service he receives once the no-member-liability rider is attached (as it is in many cases). Such a program could not have been honestly offered without significant and probably preponderant cooperation from Michigan physicians.

All physicians know who the provider is. All physicians think they know who the consumer is but it is quite apparent that they do not know him well. Physicians know only their patients who are merely one part of the consumer body. The other part may be industry-labor, big government, large pressure groups, or even small effective minority groups in industry, labor, society, or medicine. To these others Blue Shield may be a means to control physicians!

Physicians must be advised that acceptance of the new MVF is an act of faith. Unless the honest expectations of almost every physician in this state have been identified and met, and unless their emerging expectations are met as these expectations in time become the majority, the physician's faith will have been betrayed. He has given up his rights and duties for naught.

Unlike a machine which operates as directed, the Blue Shield program is a creature which may act independently. Such a creature requires far more strength and far greater surveillance than a machine for proper control. It is doubtful that organized medicine can ever act with the unity necessary to provide this strength and surveillance. The characteristic individuality of physicians may prevent adequate control ever being realized. Careful and close adherence to clearly defined and understood first principles are necessary but does not appear practical under the circumstances.

Doctor, your Shield is showing. What will you do about it?

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WHERE WE'D BE WRITING COPY

From the East Jordan News-Herald

"We like the imagery of our enterprise, white knight of freedom, last bastion of individual rights, guardian of Democracy, and the rest of the cliches which at one time or another have been used in describing the role of the "fourth estate."

"And so it's with a bit of trepidation that we offer our commentary concerning at least one aspect of the status of the medical profession—or the "first estate."

"Today, many small communities are without the services of doctors—and this phenomena appears as a growing trend.

"By population statistics and other distributive comparisons, these communities are entitled to medical service—one and sometimes as high as a half dozen doctors.

"YET, THEY HAVE NONE.

"And, by contrast, other communities may be over-blessed with medical men. The per capita ratio gyrates wildly from city to city or even between adjacent communities.

"In each instance, there may be reasons for these differences in the amount of medical service available.

"This may be due to the presence of an outstanding hospital; an outstanding clinic; the location of the community or its particular assets; the cooperation of local merchants and civic leaders in creating an amiable medical climate.

"These are just a few of the reasons that one community of 4,000 people may have 6 or 8 doctors while another community of 4,000 has one doctor, or none.

"The medical profession itself has recognized this disparity in medical placement and has sought by its own enterprise to place doctors where they are needed—through voluntary placement agencies that try to help new doctors in locatiing.

"BUT SUCH AGENCIES can only do a certain amount. Frequently, legislation may be against them—such as it is here in Michigan where future practitioners must pass a lengthy basic science exam. This requirement contributes to the doctor shortage in Michigan by putting up a bar against doctors from other states who might want to settle here since such examinations require a long brush-up period for the doctor who has been out of school for five to ten years—when he is really at the peak of his efficiency.

"However, if the inequitable distribution of doctors continues to develop along its present patterns, it would seem inevitable to us that some day Big Brother will start dictating the assignment of physicians.

"This would be reprehensible.

"However, since the constitutionality of individual rights seems to be set in terms of political expediency in our modern world, it would be difficult to predict what might happen—if Big Brother starts meddling again with medicine (witness our clogged hospitals and spiraling medical costs since Medicare started).

"The justification for governmental placement of physicians might be established on the basis of a general philosophy that since the state supports medical schools with tax dollars, it should have a voice in regulating some of the affairs of those who have benefited.

"IF THAT SHOULD ever take place, total regimentation of the entire populace could then follow. The government, by the same reasoning, could start ordering teachers to where they might be needed, engineers to certain type of projects.

"In short—anyone who had ever accepted a cent of educational subsidy, directly or indirectly, would then become a pawn in the affairs of government.

"And we can't help but close this thought for the week with facetious observations that if such a sorry state of affairs ever transpires, even newspaper editors who had trained at a public university could also be ordered to a duty assignment. With a certain insight as to our own status in the eyes of Big Brother, there's a good possibility that we'd all be typing copy in Hell."

BLUE SHIELD PRESIDENT SAYS:

Private Sector Can Meet New Health Care Demands

BY MICHIGAN MEDICAL SERVICE

"The private sector has the capability to meet the demand for increased medical care within a sound economic structure without government intervention," John C. McCabe, president of Michigan Blue Shield, told Michigan physicians at the annual meeting of the corporation, Sept. 24 in Detroit.

The members met in conjunction with the annual convention of the House of Delegates of the Michigan State Medical Society.

"Medical care will cost more — because it will be worth more," Mr. McCabe said, "just as it is worth more today than yesterday."

"However, I believe that the incremental costs will not be abusive. I am convinced, as well, that we will be able to work together to see that this will be true."

The Blue Shield president said much current criticism of private medicine comes from those "who are less concerned with correcting what they call the faults of the Medical economy than they are with redesigning it to suit their own philosophical views."

Mr. McCabe declared:

"There are those who feel that the situation calls for less continuity and more change and that the problems are such that radical redesign is the only answer and that revision and readjustment will be ineffective.

"The contrary is true. Crucial to our success is a benefit program to which maximum physician cooperation has been committed. Only through a more nearly total physician participation can we assure the public and the large group customer — as well as the critical in and out of government — that our subscribers will be able to receive services with a minimum of difficulty, with an assured level of quality, and at a cost which is equitable for the physician and reasonable for the public."

Mr. McCabe said the growing demand for more pre-paid medical service in the private sector is reflected by increasing enrollment. By July of this year Blue Shield was serving more than 5,536,000 people in its program — 63.6 per cent of the State's population — and its subscription income, excluding government business, has reached the $150,000,000 a year level and will achieve a $175,000,000 rate next July.

Blue Shield will pass the 8,000,000 claims per year mark this year, Mr. McCabe said, and will pay 10,000,000 claims in 1969. In 1970 the figure will rise to nearly 20,000,000 he said.

Mr. McCabe reported that Blue Shield's Conversion to its MVF, or Michigan Variable Fee program has passed the million member mark and will have been extended to more than 3,500,000 persons, or 80 per cent of non-government Blue Shield membership, by the end of 1968.

The program is designed to meet virtually all medical care costs without regard to patient income.

Discussing other operational activities for the first half of 1968, Mr. McCabe said that Blue Shield employs 1,343 people, more than 33 per cent higher than in the summer of 1967, "and three and one-half times what employment was when I came to Blue Shield less than three years ago."

The growth has forced major systems revisions and development of new computer techniques, Mr. McCabe noted, and innovations such as new plastic coated membership cards now being manufactured for use in "charge plate" techniques to eliminate most paper work and speed service.

It has also resulted in need for the new joint Blue Shield-Blue Cross service center complex to the west of the Chrysler Freeway north of Jefferson.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promote the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Adnan Alshbkhoun, M.D., 33100 12 Mile Road, Farmington 48024

Joseph F. Burtka, M.D., 16505 John R. Street, Madison Heights 48071

Mary L. Marshall, M.D., 1389 W. Maple Ave., Adrian 49221

Evangeline D. Mojica, M.D., 140 Elizabeth Lake Road, Pontiac 48053

Pablo A. Mojica, M.D., 140 Elizabeth Lake Road, Pontiac 48053

William J. Passinault, M.D., 26 Sheldon Ave., S.E., Grand Rapids 49502

Everton Quadros, M.D., Blissfield 49228

J. Patrick Quigley, M.D., 31815 Southfield Road #14, Birmingham 48009

Leif G. Suhrland, M.D., Dept. of Medicine—MSU, East Lansing 48823

William H. Swartz, M.D., 2335 S. Commerce Road, Walled Lake 48088

Explain How Medicare Patients Will Pay 10% More in 1969

Examples of how the 10 per cent increase will effect Medicare beginning January 1. The 10 per cent increase in the amount that patients will pay for hospitalization under Medicare was announced in September by Wilbur J. Cohen, secretary of HEW.

Following are some examples:

A patient now pays the first $40 of his hospital bill, Medicare covering the balance thru the 60th day of hospitalization. Beginning Jan. 1, the patient will pay the first $44.

The patient pays $10 a day from his 61st to his 90th day of hospitalization. This increases to $11 a day, with Medicare handling the balance.

The patient pays $20 daily for the next 60 days. This will be raised to $22.

Should the patient enter a nursing home after hospitalization, his first 20 days of care are free of charge. After that he pays $5 a day from the 21st day to the 100th day, with Medicare taking care of the balance. The $5 rate increases to $5.50 a day.

Cohen attributed the rate rises to increasing hospitalization costs, which he blamed on "a multiplicity of reasons." He said a hospital stay of an elderly Medicare beneficiary averages about $600.

SAFETY TIPS

Wearing a seat belt would have saved 40 percent of those killed in highway accidents, University of Michigan safety research shows.

Driving with bald or worn tires at high speeds on wet concrete is like driving on ice, according to the University of Michigan Highway Safety Research Institute.

LAUDS NEWS EXTRA

Michigan Medicine's newsletter was recently given recognition by an American medical society executives association study.

The front page of a recent issue was reproduced in the organization's newsletter with the comment:

"Michigan's eight-page brown ink on blue paper is a quality production using bleed-offs and an interesting variety of articles. Along with the careful placing of articles by their importance, the issue is used to stress a particular coming event."

Work is proceeding on the new $24 million Basic Science Building of the Wayne State University Medical School. The building, which will be only slightly smaller than Cobo Hall, will have a total area of 482,510 gross square feet. The teaching-research facility, at the southeast corner of Canfield and Brush, will help make it possible to increase the WSU medical school class from 125 to 200.

AMA Official Describes Primitive Viet Facilities

American physicians are shocked by the primitive facilities at provincial hospitals in Vietnam, said Malcolm E. Phelps, M.D., AMA Vice-President and former chief of the "Volunteer Physicians for Vietnam" program, at an anniversary luncheon of the Michigan Health Council recently. "Some places we have a microscope, some places we don't," he continued.

Sixteen million South Vietnamese civilians have only 158 practicing native doctors and 1,800 hospital beds. These beds are often occupied by two, three, or four patients, while others are bedded on the floor, Doctor Phelps said.

Tuberculosis, he reported, is the most prominent disease, and most of the people have intestinal parasites. Opportunities for disease observation are unlimited, the AMA Vice-President said. "I can show you acres of anything you can name."

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Corrective Action Needed

Any improvement in the public relations of the physician and the medical society must be earned through the day to day conduct of each physician in his private practice. The remaining time is short and the need for corrective action is now. The image of the modern physician must be projected as that of a highly trained scientist who also possesses an understanding heart; a master of the heart as well as the science of medicine.

—Charles E. Farber, M.D., President,
Kent County Medical Society
Excerpts from "President's Message,"
Bulletin of the Kent County Medical Society

ANDERSON TO HEAD U-M HEALTH SERVICE

Robert E. Anderson, M.D., formerly of Flint and now of Ann Arbor, is the new director of the University of Michigan Health Service. A graduate of Michigan State University and the University of Michigan Medical School, he has been a member of the U-M Health Service staff since 1966. Doctor Anderson is a Fellow of the American School Health Association and the American College Health Association and a member of the American College of Sports Medicine.

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Mental and Public Health Expenditures For State Reported

Several observations may be made from a study of the three accompanying tables and other data in the *Michigan State Economic Record.*

The following notes are observable from the data:

1. State expenditures on mental health have increased from $34,671,000 in 1950 to $122,674,000 in 1967, or a 254% increase over the 18 year period.

2. State expenditures on public health have increased from $16,791,000 in 1950 to $36,119,000 in 1967, or a 115% increase over the 18 year period.

3. The allotment of funds for mental and public health purposes, although constantly increasing over the years, has maintained a rather constant percentage of total state expenditures (6% and 2% respectively).

The Detroit Maternity and Infant Care Project, funded in 1964 under a U.S. Children's Bureau grant to the Detroit Department of Health, gives maternity and infant care services for high risk medically indigent families. The staff, directed by William F. Goins, M.D., has given care to approximately 3,000 patients. The above photo was taken at one of the six hospital clinics.

4. Percentage changes in mental and public health expenditures seem to be on the upswing in the latter sixties with greater gains being made in the mental health area.

It should also be noted that the 1968 schedule of state expenditures shows no significant change in past trends in the mental and public health fields.

These three tables are from *Michigan State Economic Record,* Vol. 10, No. 4.

TABLE I
STATE EXPENDITURES
(in thousands)

Year	Mental Health	Public Health	Total Expenditures** (all functions)
1950	$ 34,671	$16,791	$ 556,519
1955	45,860	20,270	757,846
1960	71,681	25,422	1,107,786
1961	75,957	23,698	1,175,138
1962	81,517	25,652	1,243,830
1963	83,475	25,556	1,306,335
1964	87,206	29,296	1,405,490
1965	93,974	31,293	1,535,996
1966	104,632	35,780	1,822,255
1967	122,674	36,119	2,194,257

Table I shows the actual dollar amounts spent on mental and public health in Michigan for 1950-67

**includes mental health, public health, education, highways, public welfare, general government, public safety, and other expenditures.

TABLE II
PERCENTAGE OF TOTAL EXPENDITURES

Year	Mental Health	Public Health
1950	6%	3%
1955	6%	3%
1960	6%	2%
1961	6%	2%
1962	7%	2%
1963	6%	2%
1964	6%	2%
1965	6%	2%
1966	6%	2%
1967	6%	2%

Table II shows the percentage of total expenditures allocated to mental and public health in Michigan for 1950-67

TABLE III
PERCENTAGE CHANGE OF MENTAL
AND PUBLIC HEALTH EXPENDITURES

Year	Mental Health	Public Health
1950	—	—
1955	3%	2%
1960	6%	2%
1961	6%	—7%
1962	7%	8%
1963	2%	.4%
1964	4%	14%
1965	8%	7%
1966	11%	14%
1967	17%	.9%

Table III manifests the yearly percentage changes of mental and public health expenditures in Michigan for 1950-67.

Marriage Rate Up, Predict New Population Boom by 1978, or Sooner

The Health Insurance Institute reports the United States may soon be in the midst of another population explosion. Current estimates indicate a new baby boom can be expected within five to ten years or possibly sooner.

Total births in 1967 were 3,533,000, almost 100,000 fewer than the previous year. However, professional demographers say that there will be a record number of babies born in the 1970's, with a good chance that the population will double and reach 400 million persons by the end of the century.

The rise in marriages to 1,913,000 in 1967 is one indication that the predictions may be true. Also a new crop of eligible husbands — young men between 21 and 24, in short supply since 1956, are now coming of age.

The Institute further notes that despite the use of birth control pills, the size of families will not necessarily be reduced. The pills are frequently used to allow couples to space their offspring more conveniently.

Irregardless of the pattern of fluctuation, the Institute says the traditional peak baby months of summer are expected to continue. During July, August, and September of 1968 about one million babies are expected to be born in the United States.

Physicians interested in more details can obtain *Health Insurance News,* May 1968, published by the Health Insurance Institute, 277 Park Avenue, New York 10017.

STATE BUSINESSMEN FAVOR TAX CREDITS TO HELP ENCOURAGE REMODELING

The National Federation of Independent Business reports that 63 per cent of the Michigan businessmen who answered a survey favor HR 17252 introduced by Representative Hale Boggs to allow property owners to deduct a part of their costs of renovating old buildings from income tax returns.

The Michigan survey found 32 per cent opposed to the Boggs bill, and five per cent undecided.

The Boggs anti-slum legislation would allow property owners to deduct a portion of money spent to recondition old buildings provided that their usefulness either for rental or business purposes is improved.

The national poll showed 65 per cent in favor, 31 opposed and 4 undecided.

LIABILITY RATES UP IN 22 STATES; NOT MICHIGAN

Revisions in the basic limit rates for physicians and surgeons professional liability insurance in 22 states were announced today by the Insurance Rating Board on behalf of its member and subscriber companies. Michigan was not included.

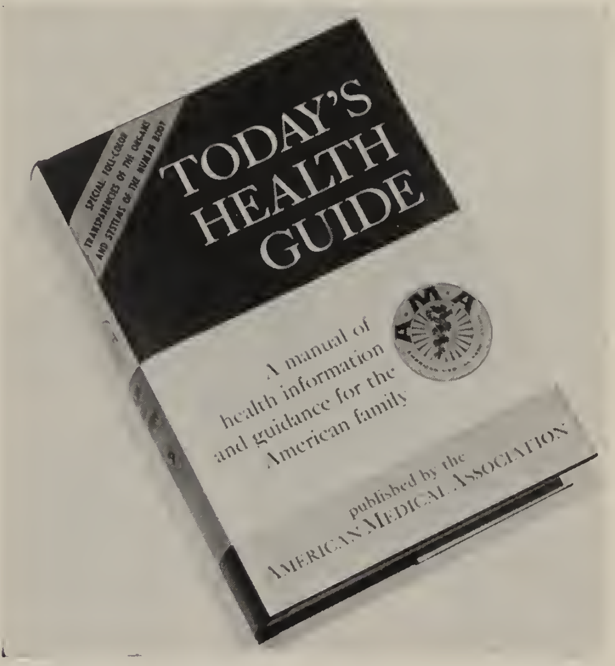
The revisions in basic limit rates result in increases in 21 states and a reduction in one. In the midwest, the Illinois rates went up 20 per cent; Indiana 30 per cent; Ohio 75 per cent. California rates went up 38.2 per cent.

Adverse underwriting experiences were cited as the reasons for the increases.

TEDDY SAID IT WELL

"In a republic like ours the governing class is composed of the strong men who take the trouble to do the work of government, and if you are too timid or too fastidious or too careless to do your part in this work, then you forfeit your right to be considered one of the governing and you become one of the governed instead. . ."

Theodore Roosevelt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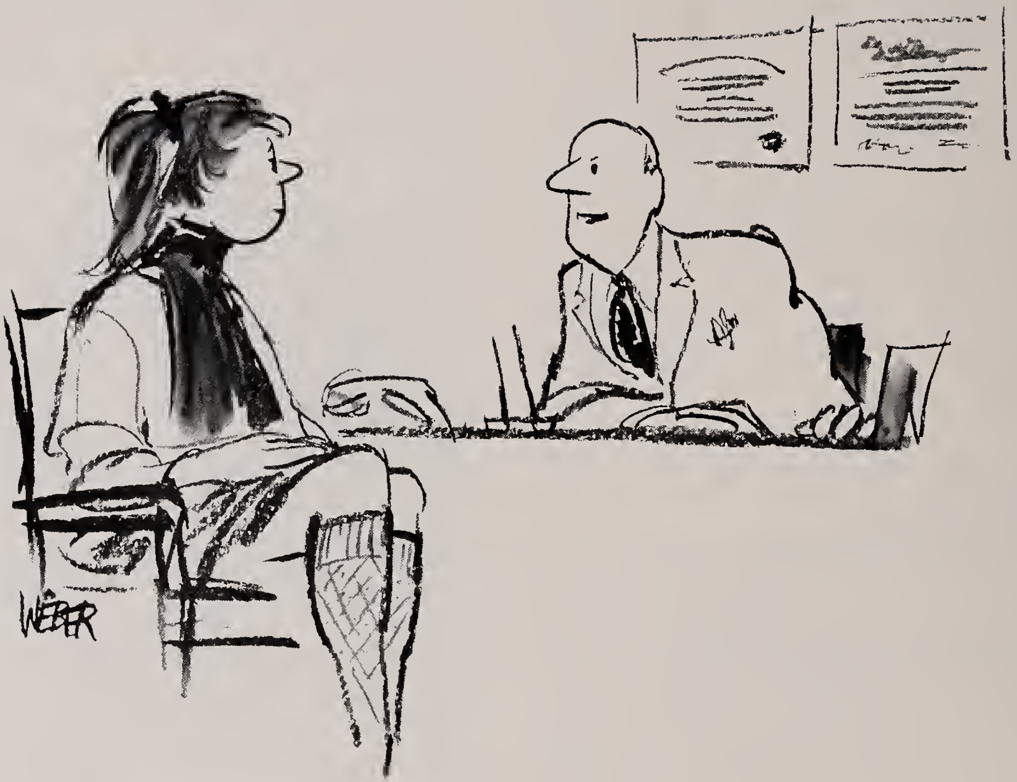
County medical societies are purchasing copies of the AMA Today's Health Guide book for presentation to libraries, schools and other community outlets. The book, which physicians might like to have available in their waiting rooms, contains 640 pages of general advice. Copies are available at cost from the AMA at $5.95. More than 20,000 diseases, illnesses, medical conditions and subjects are thoroughly covered, with more than 300 illustrations.



"Now that your acne is clearing up nicely, it might be a good idea if you started losing some weight."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8

70 Medical Research Projects Supported by Michigan Heart Association

Michigan researchers are now working on 70 Michigan Heart Association supported studies. Total of the grants-in-aid is $551,039. Other expenditures, including $165,000 — 60% of all monies sent to the American Heart Association — brought MHA's total research support during the fiscal year beginning July 1 to about $800,000.

Michael C. Kozonis, M.D., Pontiac, president of the Association, says that, "By the end of this year, our 19th, MHA will have spent about $7,200,000 on research in Michigan." The funding came from the Michigan United Fund, supplemented by Memorial Gifts, money willed or given the Association in honor of a friend or relative, victim of heart disease.

Sixty-one of the projects are in the three Michigan medical schools; 31 at Wayne State; 23 at University of Michigan; and 7 at Michigan State. Three are at Henry Ford Hospital in Detroit, and one each at the Rehabilitation Institute, and Sinai, Providence, and Detroit Memorial Hospitals, all in the Detroit area, the University of Detroit, and Blodgett Memorial Hospital, Grand Rapids.

MHA also gives a total of $70,000 in supplemental funds to the deans of the three medical schools, and uses $17,500 to support the research of medical students. These are in addition to the grants-in-aid, which range from $2,500 to $12,000, and are used to hire technicians and buy supplies.

The researcher, their institutions, and the titles of their projects, follow:

WAYNE STATE UNIVERSITY

HANLEY ABRAMSON, Ph.D., College of Pharmacy, "Cardenolide Alkylating Agents as Potential Irreversible Inhibitors of Transport Adenosine Triphosphatase."

GORDON F. ANDERSON, Ph.D., Dept. of Physiology and Pharmacology, "Ultrastructural Changes and Metabolism of Warfarin Sodium."

AUGUSTIN ARBULU, M.D., Dept. of Surgery, "Myocardial Revascularization Using a Newly Created Arteriovenous Fistula."

MARION I. BARNHART, Ph.D., Dept. of Physiology and Pharmacology, "Leucocytic Function During Thrombosis."

RICHARD J. BING, M.D., Dept. of Medicine, "Myocardial Failure; Myocardial Contractility; Studies on the Capillary Circulation of the Heart."

CHARLES M. COWAN, M.D., Dept. of Medicine, "Measurement of Coronary Blood Flow Using Rubidium-84, A Positron Emitter."

DANICA DABICH, Ph.D., Dept. of Biochemistry, "Catabolism of Proteins."

MYRON K. DENNEY, M.D., Dept. of Surgery, "Venolymphatic Communications."

SIGMUNDUR GUDBJARNASON, Ph.D., Dept. of Medicine, "Energy and Lipid Metabolism of Infarcted Heart Muscle."

RAYMOND L. HENRY, Ph.D., Dept. of Physiology and Pharmacology, "In vivo Observations and in vitro Analysis of Experimental Thrombi."

TODD S. ING, M.D., Dept. of Medicine, "Determination of Intra-Renal Distribution of Blood Flow with Radioactive Xenon in Renovascular Hypertension."

A. MARTIN LERNER, M.D., Dept. of Medicine, "Studies of a Severe Murine Virus Myocarditis and Cardiomyopathy."

LAWRENCE LEVINE, Ph.D., Dept. of Biology, "Cytochemical Adenosine Triphosphatase; Loci of Elementary Mechano-chemical Transduction Sites."

EBERHARD F. MAMMEN, M.D., Dept. of Physiology and Pharmacology, "Blood Coagulation Changes Related to Shock."

D.S. McCANN, Ph.D., Dept. of Chemistry, "Role of Elastin in Experimental Atherosclerosis."

JOHN S. MEYER, M.D., Dept. of Neurology, "A New Method for Measuring Regional Cerebral Blood Flow in Man; Development of the Method in Monkeys."

ROBERT A. MITCHELL, Ph.D., Dept. of Biochemistry, "Pathways for ATP Synthesis and Utilization of Heart Muscle Mitochondria."

HIROSHI MIZUKAMI, Ph.D., Dept. of Biochemistry, "Studies of Hemoglobin from Cardiovascular Disease Patients."

CHARLES J. PARKER, JR., Ph.D., Dept. of Biochemistry, "A Study of the Mechanism of Relaxation in Heart Muscle."

LAWRENCE POWER, M.D., Dept. of Medicine, "Atherosclerosis and Carbohydrate Intolerance."

JEANNE M. RIDDLE, Ph.D., Dept. of Pathology, "Platelet Ultrastructure in Thrombotic Diseases."

JERRY C. ROSENBERG, M.D., Dept. of Surgery, "Effect of Various Resuscitative Measures on the Hemodynamic and Metabolic Changes Produced by Shock Secondary to Acute Massive Pulmonary Embolus."

VISHWANATH M. SARDESAI, Ph.D., Dept. of Surgery, "Myocardial Carbohydrate Metabolism in Endotoxin Shock."

IRWIN J. SCHATZ, M.D., Dept. of Medicine, "Study of Triglyceride and Fat Synthesis in Patients with

(Continued on 1403)

the complex picture
moderate to severe anxiety...

ere is a new reason
' prescribing Mellaril (Thioridazine HCl)

ectiveness in
ed anxiety-depression

recognized for its usefulness in the
nent of moderate to severe anxiety,
ril is now also known to be effective
st mixed anxiety-depression.

the symptoms of anxiety states are
ult to sort out—even with the most careful
ng. The patient may manifest symptoms of
ion, restlessness, insomnia, somatic
laints. But what of the depression that may
xed in the total picture? It is reassuring
ow that Mellaril may be prescribed—with
g possibilities of success—when there is
ty alone or a mixture of anxiety
epression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170

Louie!
You're
back.

Louie lost weeks with acute shoulder bursitis. That's
of pain, stiffness and tenderness…and also a lot of
It might have been different with **Butazolidin®**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, for

3ut please don't forget this:

Contraindications: Edema; danger of cardiac lecompensation; history or symptoms of eptic ulcer; renal, hepatic or cardiac damige; history of drug allergy; history of blood lyscrasia. The drug should not be given when he patient is senile or when other potent lrugs are given concurrently. Large doses f the alka formulation are contraindicated n glaucoma.

Varning: If coumarin-type anticoagulants are jiven simultaneously, watch for excessive ncrease in prothrombin time. Instances of evere bleeding have occurred. Persistent or evere dyspepsia may indicate peptic ulcer; erform upper gastrointestinal x-ray diagostic tests if drug is continued. Pyrazole ompounds may potentiate the pharmacologic ction of sulfonylurea, sulfonamide-type gents and insulin. Carefully observe patients eceiving such therapy. Use with caution in e first trimester of pregnancy and in patients ith thyroid disease.

recautions: Before prescribing, carefully elect patients, avoiding those responsive to utine measures as well as contraindicated atients. Obtain a detailed history and a comlete physical and laboratory examination, cluding a blood count. Patients should not xceed recommended dosage, should be losely supervised and should be warned to iscontinue the drug and report immediately fever, sore throat, or mouth lesions (sympms of blood dyscrasia); sudden weight gain vater retention); skin reactions; black or rry stools or other evidence of intestinal emorrhage occur. Make complete blood ounts at weekly intervals during early therapy nd at 2-week intervals thereafter. Disconue the drug immediately and institute ountermeasures if the white count changes gnificantly, granulocytes decrease, or imature forms appear. Use greater care in the derly and in hypertensives.

dverse Reactions: The more common are ausea and edema. Swelling of the ankles or ce may be minimized by withholding dietary lt, reduction in dosage or use of diuretics. elderly patients and in those with hypertenon the drug should be discontinued with the pearance of edema. The drug has been asciated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka **Geigy**

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicata

The Divorced Depressive:

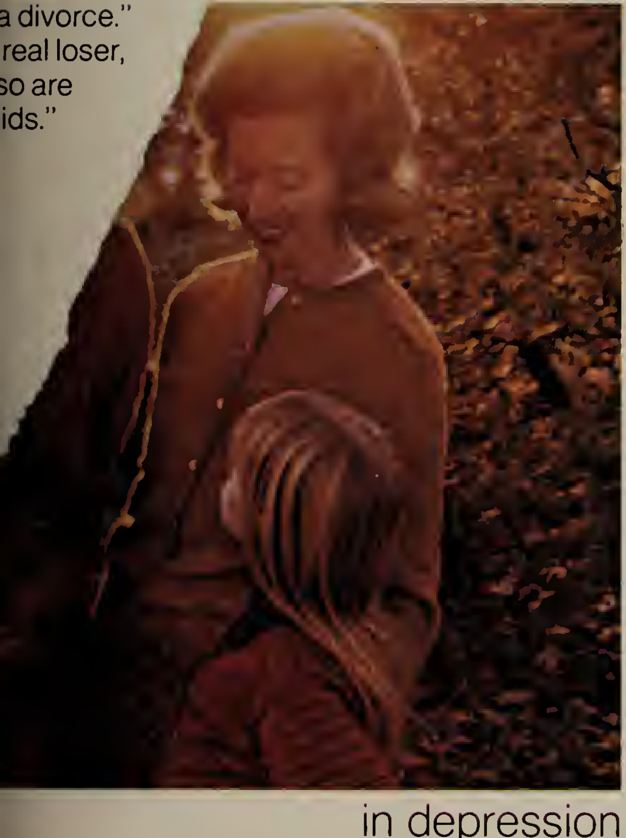
“Forty Forgotten

“Had a large wedding.”

“Had a fine home and family.”

Forlorn”

a divorce.”
real loser,
so are
ids.”



The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

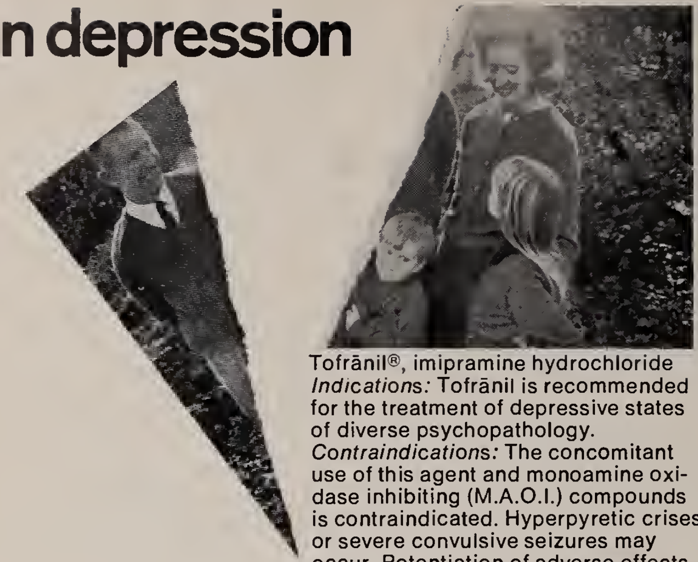
Turn page for brief summary of Prescribing Information.

in depression

Tofrānil® imipramine hydrochloride

Geigy

in depression



Tofrānil® Geigy
imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

t's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N.J. 08101

Campbell's
CONDENSED
SOUP

In childhoo

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma,
hypotonic reflexes, nystagmus, pinpoint pu
tachycardia; continuous observation is necessa

Adverse Reactions: Side effects reported
Lomotil therapy include nausea, sedation, dizzi
vomiting, pruritus, restlessness, abdominal dis
fort, headache, angioneurotic edema, giant urti
lethargy, anorexia, numbness of the extrem
atropine effects, swelling of the gums, eup
depression and malaise. Respiratory depressio
coma may occur with overdosage.

Dosage: The recommended initial daily do
given in divided doses until diarrhea is contr
are as follows:

iarrheas...

- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ....0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

lren: Total Daily Dosage

mo. . . . ½ tsp.* t.i.d. (3 mg.)
2 mo. . . ½ tsp. q.i.d. (4 mg.)
yr. . . . . ½ tsp. 5 times daily (5 mg.)
yr. . . . . 1 tsp. t.i.d. (6 mg.)
yr. . . . . 1 tsp. q.i.d. (8 mg.)
2 yr. . . . 1 tsp. 5 times daily (10 mg.)
ts: . . . . 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

on 4 cc. per teaspoonful.

itenance dosage may be as low
ne-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127:*475-484 (Oct. 4) 1965. 2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125:*758-763 (Aug. 27) 1964. 3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia 2:921-922 (Nov. 27) 1965. 4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine

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Indianapolis, Indiana 46206

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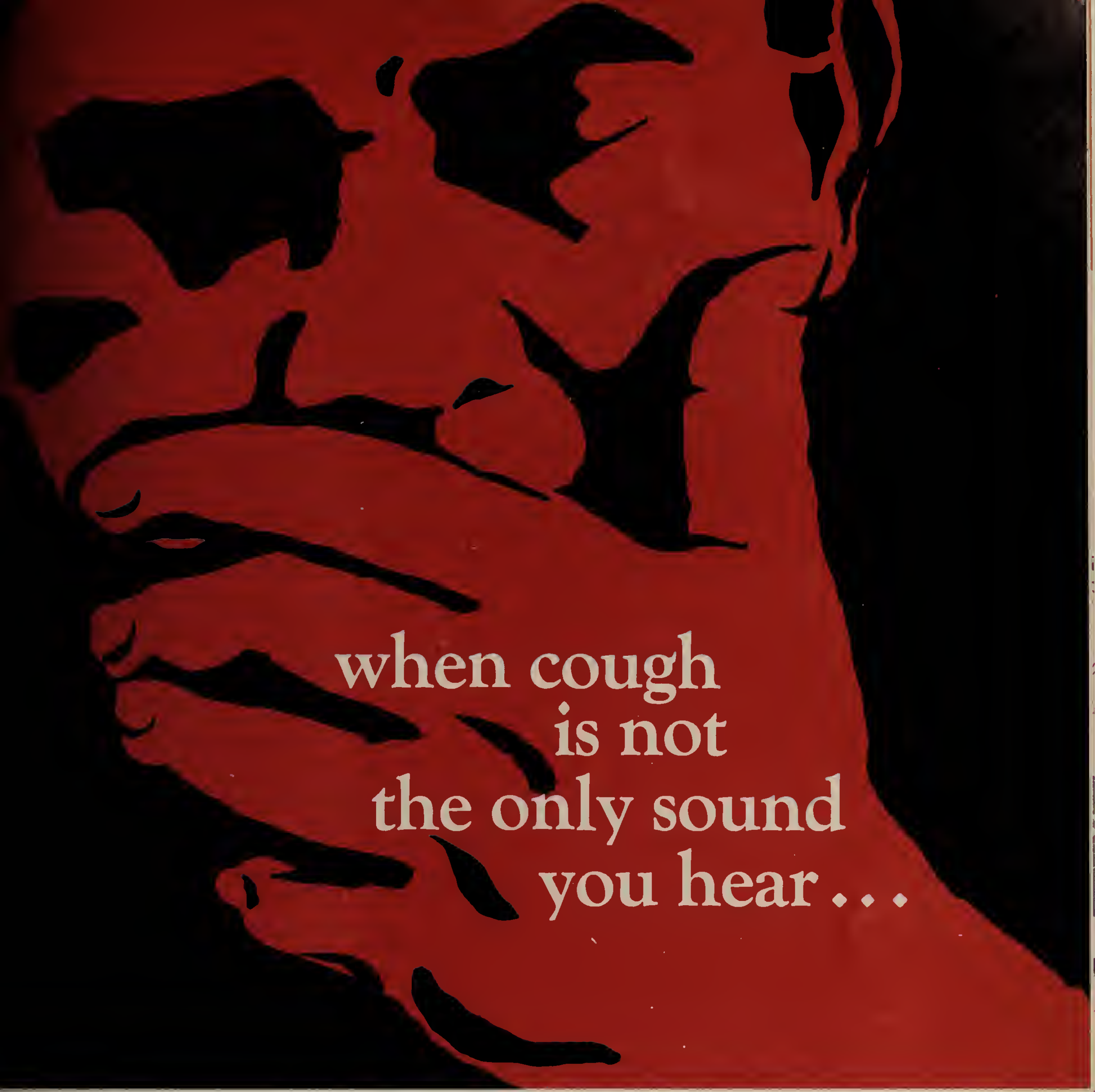

OMNI-TUSS® b.i.d.

. . . because OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

When it's more than a bad cold

your patient can feel better
while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8

Various Types of Hyperlipidemia and their Inter-relationships with Glucose Metabolism."

ROBERT S. SHEPARD, Ph.D., Dept. of Physiology and Pharmacology, "Changes in Cardiac Performance in the Conscious Dog in Response to Automatic Agents, Pacing, Exercise, and Anesthesia."

ALLEN SILBERGLEIT, M.D., Dept. of Physiology and Pharmacology, "An Experimental and Clinical Study of Platelet Aggregation in Man and the Relationship to Thrombosis."

CALVIN L. STEVENS, Ph.D., Dept. of Chemistry, "Synthesis of Aminosugar Cardiac Glycosides."

DEMETRIOS C. TRIANTAPHYLLOPOULOS, M.D., Dept. of Physiology and Pharmacology, "Studies on Lysed Fibrinogen."

ALEXANDER J. WALT, M.D., Dept. of Surgery, "Massive Blood Transfusion; A Prospective Study of the Associated Biochemical Hemodynamic and Coagulation Changes."

ROBERT F. WILSON, M.D., Dept. of Surgery, "Cardiovascular Changes in Shock and Trauma."

BENNIE ZAK, Ph.D., Dept. of Pathology, "Soluble Adenines, Nucleic Acids, Nucleic Acid Nucleotides and Base Pair Ratios, Enzymes, Total and Soluble Proteins, Lipid Levels and Trace Metals of Heart Muscle."

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WALTER M. BAIRD, M.D., Dept. of Pharmacology, "An Investigation of the Pharmacodynamic Effects of Cardiac Antiarrhythmic Agents in the Intact Animal by Radioisotopic Tracer Techniques."

JOHN G. BATSAKIS, M.D., Dept. of Pathology, (A) "Iatrogenic Aberrations of Serum Enzyme Activity and Methodological Assessment of LDH Isoenzyme Techniques." (B) "Serum Lipoproteins, Their Electrophoretic and Thermal Characteristics."

LLOYD BECK, Ph.D., Dept. of Pharmacology, "Humoral Control of the Capacitance System: The Nature and Neurosecretory Control of the Renal Agent Involved."

GERALD L. BRODY, M.D., "To Determine What Proportion of Ischemic Myocardium Undergoes Necrosis in Myocardial Infarction."

JAMES CONWAY, M.D., Ph.D., Dept. of Internal Medicine, "Hemodynamic Changes in Experimental Hypertension."

WILLIAM W. COON, M.D., Dept. of Surgery, "Effect of Low Molecular Weight Dextran Upon Plasma Clearance and Tissue Distribution of C14-Cholesterol."

SUNIL K. DAS, M.D., Dept. of Internal Medicine, "Studies of Anti-heart Immunoglobulins in Patients with Cardiomyopathy and Similar Studies in Relatives of Patients with Cardiomyopathy."

JOHN R. P. FRENCH, JR., Ph.D., Institute for Social Research, "Work Overload and Risk Factors in Coronary Heart Disease."

JAMES A. GREEN, JR., M.D., Dept. of Internal Medicine, "Cardiovascular Hemodynamics in Experimental Nephritis."

SIBLEY W. HOOBER, M.D., Dept. of Internal Medicine, "Management of Hyperlipidemia in Ambulatory Patients."

DONALD R. KAHN, M.D., Dept. of Surgery, "Late Results of Open Heart Operations."

BENEDICT R. LUCCHESI, Ph.D., Dept. of Pharmacology, "Effects of Insulin Upon the Normal and Digitalized Heart."

JOE D. MORRIS, M.D., Dept. of Surgery, "Surgical Treatment of Acquired Heart Disease Including Myocardial Revascularization by Means of Direct Myocardial Perfusion With Left Ventricular Blood."

JOHN A. PENNER, M.D., Dept. of Internal Medicine, "Mechanisms of Blood Coagulation."

ERNEST W. REYNOLDS, JR., M.D., Dept. of Internal Medicine, "Evaluation of Propranolol and Quinidine in the Treatment of Quinidine Resistant Arrhythmias, Studies by Continuous Monitoring."

HERBERT SLOAN, M.D., Dept. of Surgery, "Pulmonary Function Changes in Infants with Congenital Heart Disease Undergoing Surgical Repair."

JAMES A. TAREN, M.D., Dept. of Neurosurgery, "Magnetic Obliteration of Cerebral Aneurysms."

SATHAPORN VATHAYANON, M.D., Dept. of Surgery, "Cardiac Homotransplantation: Studies of Growth in the Homograft and of the Rejection Phenomenon in Young Calves."

PAUL A. WEINHOLD, Ph.D., Depts. of Biological Chemistry and Internal Medicine, "Inhibitions of Tyrosine Hydroxylase and Norepinephrine Biosynthesis."

JOHN M. WELLER, M.D., Dept. of Internal Medicine, "Study of Antihypertensive Agents."

PARK W. WILLIS, III, M.D., Dept. of Internal Medicine, "Epidemiology and Therapy of Occlusive Vascular and Thromboembolic Disease."

WEN-JEI YANG, Ph.D., College of Engineering, "Dynamic of Gas Emboli in Cardiovascular Systems."

ANDREW ZWEIFLER, M.D., Dept. of Internal Medicine, "Experimental Thrombosis."

MICHIGAN STATE UNIVERSITY

THEODORE M. BRODY, Ph.D., Dept. of Pharmacology, "Catecholamine-Thyroid Hormone Interaction in the Rat Heart."

REXFORD E. CARROW, Ph.D., Dept. of Anatomy,

(Continued on 1411)

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Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

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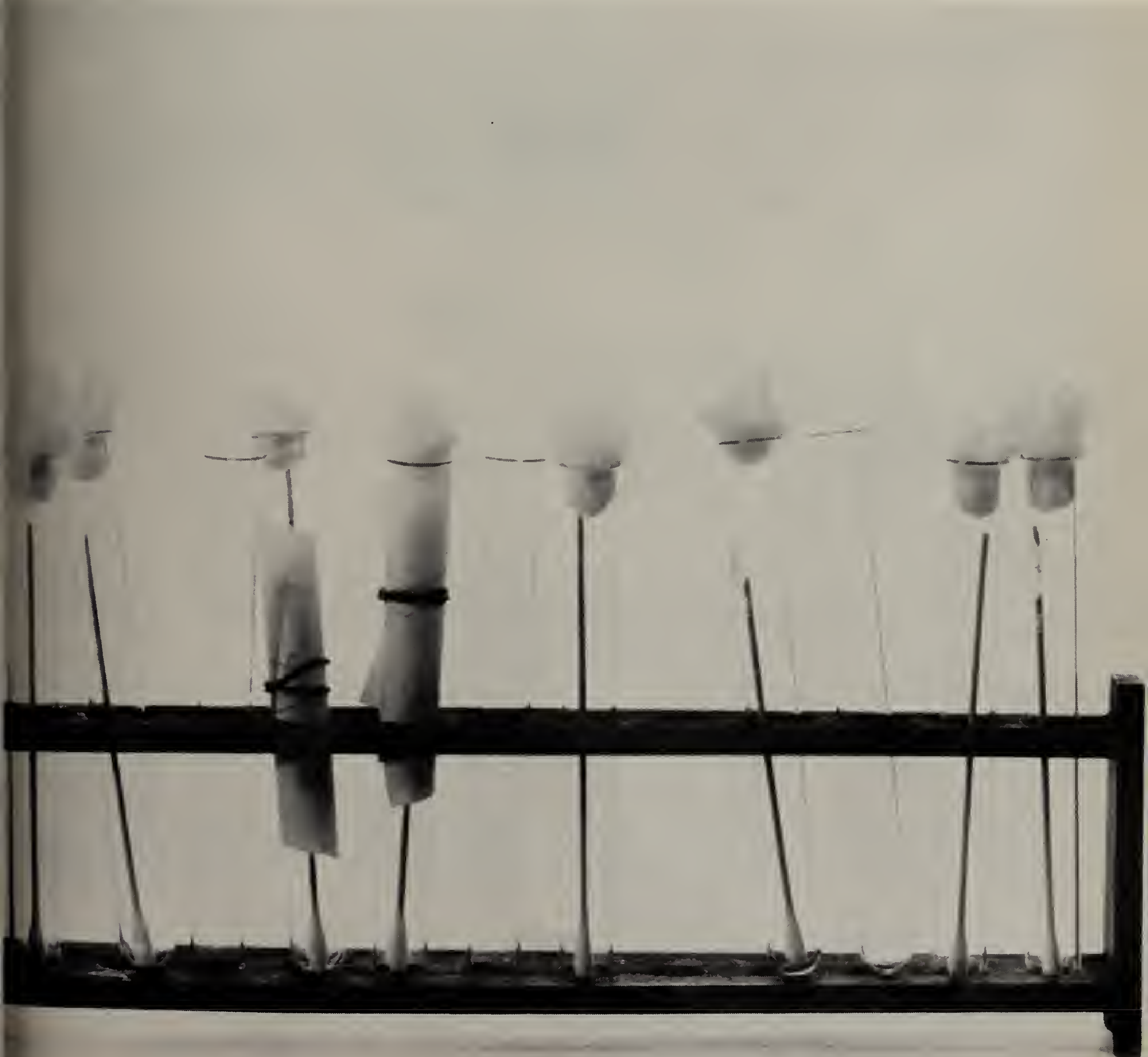

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☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

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RESEARCH PROJECTS/Continued

"Anatomy of the Sinus Node and Pulmonary Veins of Primates."

GEORGE E. EYSTER, V.M.D., Veterinary Clinic, "Studies of High Incidence Congenital Heart Disease in Inbred Cattle."

FRANCIS J. HADDY, M.D., Dept. of Physiology, "The Mechanism of Coronary Vasodilation Caused by Adrenergic Stimulation."

JERRY B. HOOK, Ph.D., Dept. of Pharmacology, "Effect of Several Saluretic-Diuretic Agents on Renal Na-K-Activated ATPase and Renal Hemodynamics."

HENRY W. OVERBECK, M.D., Depts. of Physiology and Medicine, "Vascular Responses in Experimental Hypertension."

OTHER PROJECTS

WILLIAM J. FERRELL, Ph.D., Dept. of Chemistry, University of Detroit, "Analysis of Human Cardiac Aldehydogenic Lipids."

ALBERTO MANZOR, M.D., Detroit Memorial Hospital, "Internal Revascularization of the Left Ventricle."

WALTER D. MEESTER, M.D., Ph.D., Blodgett Memorial Hospital, Grand Rapids, (A) "The Effect of Epinephrine on Lipid Metabolism." (B) "Pharmacological Evaluation of Various Drugs Blocking the positive Inotropic Action of Epinephrine."

ROBERT E. MOSHER, Ph.D., Providence Hospital, Southfield, "The Quantitative Distribution of Copper in Normal and Diseased Human Myocardial Tissue."

FRANCES E. NOE, M.D., Sinai Hospital, Detroit, "Measurement of Effective Pulmonary Blood Flow and Its Correlation with Blood Buffer Capacity in Normal Subjects and in Patients with Acquired and Congenital Heart Disease."

JAN NYBOER, M.D., D.Sc., Rehabilitation Institute, Detroit, "Evaluation of Ballistocardiography and Electrical Impedance Plethysmography."

JOSEPH D. SHORE, Ph.D., Henry Ford Hospital, "The Mechanisms of Regulation of Heart Mitochondrial Malate Dehydrogenase."

D. EMERICK SZILAGYI, M.D., Henry Ford Hospital, "An Investigation of the Use of Vascular Substitutes in the Replacement of Arterial Segments."

FRED W. WHITEHOUSE, M.D., Henry Ford Hospital, "Study of Aberration of Carbohydrate and Fat Metabolism in Various Types of Hyperlipidemia."

INTERESTING READING:

Many of the bookstores are selling a pocketbook version of "Understanding Media" by Marshall McLuhan. The highly-respected, popular author discusses two fundamental questions about the modern world: What are communications and how do communications affect mankind? The work interprets the entire process of communications from the invention of movable type through the electronic age.

PROCTOLOGY IN ANCIENT EGYPT

Since physicians are men of learning, knowledge of medical history is a necessity, not a luxury. In the absence of a history of proctology, this essay hopefully provides some insight into the management of anorectal disorders mentioned in the medical papyri.

Testifying to the quality of medicine practiced and recognizing the antiquity of the specialty of proctology, some of the knowledge passed along from ancient Egypt continues to influence present-day medicine. Enemas and suppositories are still in fashion. To unload their colons, people continue to take fruit, senna, colocynth and castor oil. The ancient Egyptians treated diarrhea, round and tapeworm infestations and bilharziasis; the medical specialists who treated anorectal disorders were held in especial esteem.

All these little known historical facts of our medical heritage should be bettter publicized to promote respect for the antiquity of our profession, to inspire a greater appreciation of this legacy from the past, and to provide moderation in evaluating our progress. — Leon Banov, Jr., M.D., Charleston, South Carolina: *Southern Medical Journal.*

Anatomy courses at colleges in Michigan and the nation are a far cry today from the lectures of 75 years ago. This photo, from the historic collection of the University of Michigan Medical School, shows five medical students: left to right, Edwin A. Murbach, Stephen C. Glidden, Howard A. Herrington, and James F. Breakey, all in the Class of 1894, and Laurence C. Grosh, right foreground, Class of 1895.

IN MEMORIAM

J. G. Bayles, M.D., Detroit

John G. Bayles, M.D., Detroit general practitioner for 40 years, died September 20. He was 67.

Doctor Bayles received his premedical education at the University of Michigan. He was graduated from the Tulane Medical School of Louisiana in 1929. His hospital affiliation was with Lincoln Hospital.

He was a 32nd degree Mason and a member of Phi Lambda Kappa medical fraternity.

M. J. Budge, M.D., Alma

Melvin J. Budge, M.D., Alma general practitioner, died September 16 at the age of 79.

A Life Member of MSMS, he had practiced in Ithaca since 1921. He also was an anesthesialogist at Gratiot Community Hospital, Alma, from 1959 until his retirement in 1966.

Doctor Budge was graduated from the University of Michigan Medical School in 1920. Previously a teacher, he served as principal of Riverdale Schools from 1910-12, as principal of McAllen School, McAllen, Texas, from 1913-14, and as superintendent of schools at Coleman, Michigan, 1914-15. During World War I he was a member of the Medical Corps.

He served on the Ithaca School Board and was a member of the American Society of Anesthesiologists.

J. S. Burleson, M.D., Grand Rapids

John S. Burleson, M.D., Grand Rapids, a former vice president of the American Proctological Society, died September 25. He was 58. Doctor Burleson was the owner and director of Burleson Hospital in Grand Rapids for 31 years.

He was graduated from the Medical College of Virginia in 1937. After serving his internship at Butterworth Hospital, Grand Rapids, he entered practice in Grand Rapids. In 1943 he served as chief proctologist at the Detroit House of Corrections.

He was a Fellow of the International Academy of Proctology and a member of the American Proctological Society, the American College of Surgeons, and Alpha Kappa Kappa.

H. Q. Groos, M.D., Escanaba

Harold Q. Groos, M.D., Escanaba physician for about 40 years, died at the age of 69.

Doctor Groos, a native of Escanaba, had been in practice there since 1928. He was a 1924 graduate of the University of Illinois Medical School.

In the past he had served as president, vice president, secretary and treasurer of the Delta-Schoolcraft County Medical Society.

He was surgeon for the Chicago & North Western Railroad and was also associated with the Harnischfeger Corporation. He was affiliated with St. Francis Hospital, Escanaba.

Doctor Groos was a member of the American Association of Railway Surgeons, Michigan Industrial Medical Association and Nu Sigma Nu.

E. L. Hansen, M.D., Battle Creek

Edwin L. Hansen, M.D., Battle Creek surgeon and gynecologist for many years, died September 29. He was 67.

Doctor Hansen was graduated in 1924 by the Loma Linda University School of Medicine in California. His internship was served at the Los Angeles General Hospital. He did postgraduate work in hospitals in Denmark, Germany and Austria.

He was a Fellow of the American College of Surgeons and a member of the Pan-Pacific Surgical Society and of numerous fraternal orders.

Doctor Hansen was the brother of Harvey C. Hansen, M.D., also of Battle Creek.

D. R. Hagge, M.D., Livonia

Donald R. Hagge, M.D., chief of surgery at St. Mary Hospital in Livonia, died September 13 at the age of 46.

Doctor Hagge was immediate past president of the Michigan Archaeological Society. Particularly interested in disease in prehistoric man, he was the author of a book on paleopathology.

He received the M.D. degree from the State University of Iowa in 1945. From 1946 through 1948 he served as a flight surgeon in the Medical Corps.

Formerly chief of staff at St. Mary Hospital, he was also affiliated with Harper and Mt. Carmel hospitals in Detroit and William Beaumont Hospital in Royal Oak.

Doctor Hagge was a Fellow of the American College of Surgeons and a member of the Detroit Surgical Society, Detroit Surgical Association, and Phi Rho Sigma fraternity.

Robert Licht, M.D., Detroit

Robert Licht, M.D., a radiologist at Mt. Carmel Mercy Hospital, Detroit, died September 26. He was 42.

(Continued on 1417)

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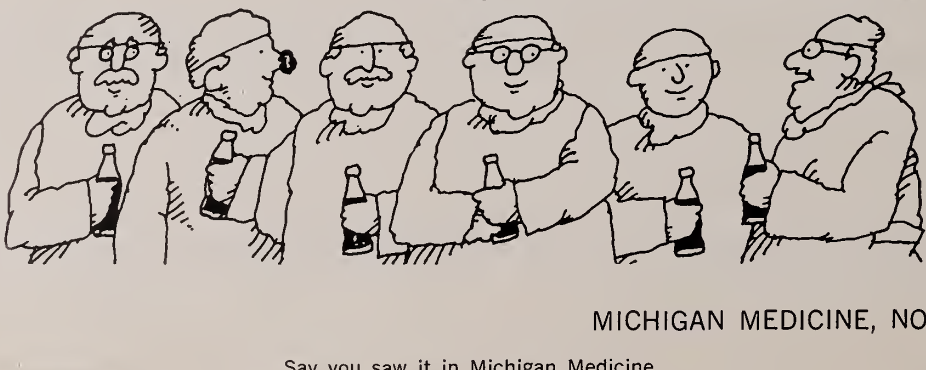
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or

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HISTOPLASMIN, TINE TEST
(Rosenthal)

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painful night leg cramps...
respond to specific therapy with
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(Quinine sulfate, 260 mg., Aminophylline, 195 mg.)

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Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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WANTED: Full time physician for automotive manufacturing plant. Good salary. Excellent fringe benefits. West side suburban Detroit area. Call for appointment. KE 5-5000, Ext. 341 or 224. An Equal Opportunity Employer.

GENERAL PRACTITIONER, with surgical experience desires to relocate in Michigan, leading to possible permanent association. Age 55, good health, married, Michigan license. Reply Box 222, Newberry, Michigan 49868.

PSYCHIATRIC RESIDENCIES: Comprehensive Mental Health Center serving S.E. Michigan. Affiliated with Dept. of Psych. Univ. of Michigan. Resident's training & experience includes: acute mentally ill; community psychiatry; individual, family, and group psychotherapy; forensic psychiatry; psychosomatic medicine; etc. Masters Degree may be obtained. 3-year starts $9,876. $12,000 grant available eligible physicians in practice 4+ years. Brochure on request. Write: Director of Training, Dept. 6, Box A, Ypsilanti, Michigan 48197.

GENERAL SURGEON: Board Certified or Eligible; 269 bed, General Medical and Surgical Hospital in Michigan's Upper Peninsula. Licensure any state, salary dependent upon background and qualifications. Excellent benefits for retirement, vacations, sick leave, and professional improvements. Non-discrimination in employment. Contact Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

OBSTETRICIAN - GYNECOLOGIST to take over busy west Detroit suburban Ob-Gyn practice. No investment or obligation. This opportunity developed unexpectedly and is available immediately. Qualified applicants given careful consideration. Write Box 17, 120 West Saginaw Street, East Lansing, Michigan 48823.

MEDICAL DIRECTOR: Single County Health Department. Population approximately 165,000. Department employs approximately 45. General Health programs. Excellent relationship with physicians' groups. Outstanding year round recreational activities. Excellent schools. Desire M.D., M.P.H.; will consider M.D. willing to obtain M.P.H. with assistance, within three years of employment. Location Western Michigan. Salary open, in excess of $21,000, depending on qualifications and Experience. Many fringe benefits. Send resume to James V. Wells, Muskegon County Board of Health, County Building, Muskegon, Michigan 49440.

TWO G.P.'s Desire a third G.P. as an associate in Flint, Michigan. Must be young, ambitious and thorough with above average capabilities. Practice is unique and the income considerably above average. Reply: Box 15, 120 W. Saginaw Street, East Lansing, Michigan 48823.

WANTED: General Practitioners, Internist, and Pediatrician to practice in modern building. Good opportunity for young man coming out of service. Allen Medical Building, Bay City, Michigan 48706.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. There are five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

FOR SALE: Complete office equipment, drugs, specula, desk, files, cabinets, dark room, 200 MA Rotating Anode, waiting room, examining room. Phone 868-1401 Detroit.

INTERNAL MEDICINE AND GENERAL PRACTITIONER: Excellent opportunity for Internist and for General Practitioner. Beautiful 52 bed modern hospital, located near Lake Michigan. In industrial and summer and winter resort area. Office space in Medical Clinic available. Contact: Robert G. Martin, M.D., Charlevoix Hospital, Lake Shore Drive, Charlevoix, Michigan 49720.

PUBLIC HEALTH PHYSICIANS — Positions available in local health departments for medical doctors with medical experience and training in public health. Salary range $20,000 to $25,000. Contact Mr. Roy Manty, Chief, Division of Local Health Administration, Department of Public Health, 3500 North Logan, Lansing, Michigan 48914. An equal opportunity employer.

GENERAL PRACTITIONER, INTERNIST, ORTHOPEDIST, OB-GYN needed for additional staff to establish 15-man medical group in Detroit. Excellent professional relationships together with financial opportunities. Reply Box 19, 120 West Saginaw Street, East Lansing, Michigan 48823.

INTERNIST — Age 40, Board Certified, military obligation complete, solo practice eight years, wishes to relocate — preferably in northern Michigan. Will consider association with other internist or solo practice opportunity in community with other internist (s) for coverage. Write Box #18, 120 West Saginaw Street, East Lansing, Mich. 48823.

WANTED: Well trained generalist with at least one or two years of residence training or board qualified or certified internist to associate with four-man clinic group in rural resort community. Ultra-modern, new clinic building soon to be under construction, directly adjoining new 30 bed hospital with excellent facilities and consultation arrangements. Outstanding local school system with essentially all new buildings and fine staff, with enrollment of 1728 pupils in system. Contact: T. R. Deur, M.D., Deur Clinic, Grant, Mich. 49327.

Doctor Licht was graduated in 1954 from the University of Michigan Medical School. From 1958 to 1960 he served in the Navy Medical Corps.

He was a diplomate of the American Board of Radiology and a member of the American College of Radiology.

J. W. MacKenzie, M.D., Grosse Pointe

John W. MacKenzie, M.D., a former chief of staff of Cottage Hospital, Grosse Pointe, died September 21. He was 75.

Doctor MacKenzie was born in Toronto, Canada, and was graduated from the Toronto Medical School in 1917. From 1917 to 1919 he served in the Canadian Medical Corps.

He began practice in Grosse Pointe in 1922.

He was a Life Member of MSMS and a member of Alpha Kappa Kappa medical fraternity.

E. W. Secord, M.D., Detroit

Eugene W. Secord, M.D., Detroit, a past president of the Detroit Academy of Orthopaedic Surgeons, died August 30. He was 65.

Doctor Secord received B. S. and M. S. degrees from the University of Detroit and he was graduated from the Yale University School of Medicine in 1932. His internship was at University Hospitals, Cleveland, Ohio. He was a fellow in orthopedic surgery at Mayo Clinic for three years and he remained on the Mayo Clinic staff for two years. He earned the M.S. degree in orthopedic surgery from the University of Minnesota.

Shortly after he began practice in Detroit in 1938, he organized the orthopaedic section at Mt. Carmel Hospital. He was also in charge of the outpatient department at Veterans Hospital.

Doctor Secord was a member of the Detroit Surgical Society, Association of Bone and Joint Surgeons, American Academy of Orthopedic Surgery, Clinical Orthopedic Society, Crippled Children Society. He was also a member of Alpha Kappa Kappa and Sigma Xi.

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Plainwell, Michigan — MU 5-8441

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M. Leroy Barry, M.D.

Dan W. Everett, M.D.
Wilbur R. King, Ph.D.

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health, and member of the American Hospital Association, Michigan Hospital Association, and National Association of Private Psychiatric Hospitals. Our extensive diagnostic treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic evaluation of neurological disorders.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

Michigan
State
Medical
Society

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

H. David Fenske, M.D., South Haven,
has been presented the Medical Merit of Honor, South Vietnam's highest civilian award, by the South Vietnamese Ministry of Health for his efforts in establishing a national eye-care program. In addition to his duties as 12th USAF Hospital Chief of Ophthalmology and ophthalmology consultant for the Pacific area, Doctor Fenske has been active in the development of the Cam Ranh City Orphanage and also in the Med-Cap civilian aid program, a voluntary medical mission.

Arthur W. Strom, M.D., Hillsdale,
was installed as president of the Michigan Society of Internal Medicine at the annual convention at Hidden Valley. He had served as a director of the society for some time.

V. A. Marks, M.D., Midland,
was the guest speaker at a recent meeting of the Midland Hospital Auxiliary.

James J. Lightbody, M.D., Detroit,
MSMS President and medical director of the Michigan Chapter of the Arthritis Foundation, was a featured speaker at a free Arthritis Forum in Battle Creek. Vance B. Lancaster, M.D., Battle Creek, was coordinator of the forum, co-sponsored by the Michigan Chapter of the Arthritis Foundation and the Calhoun County Medical Society.

Henry E. Malcolm, M.D., Lansing,
has returned to Lansing to practice gynecology after a year of practice in Freeport, Grand Bahama, Bahama Islands.

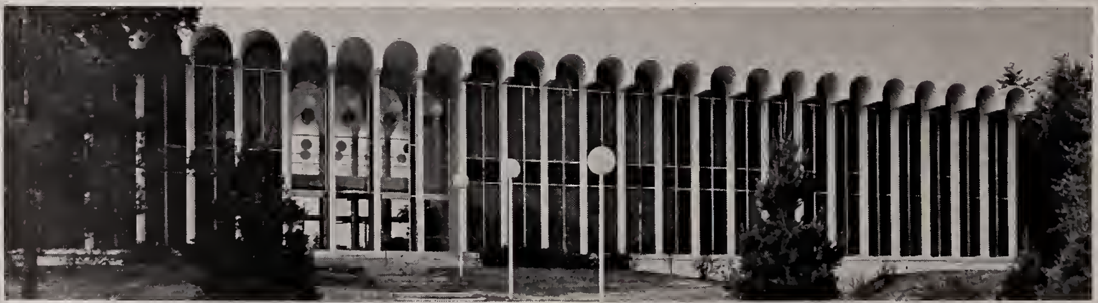
Stanley Moleski, M.D., Grand Rapids,
has announced his retirement from the office of city physician of Grand Rapids which he has occupied for 23 years.

Lambert J. Geerlings, M.D., Fremont,
was honored by Gerber Memorial Hospital with the presentation of a bronze plaque. The inscription praised him for his long service to that institution and for his dedication to the health care of the people in the community, "a source of inspiration to all those who labored with him."

William M. Chavis, M.D., Detroit,
presented a paper before the Liberian Medical Association in Monrovia, Liberia, West Africa, on "The Significance of the Papanicolaou Smear as a Screening Technique for Cancer of the Cervix in a Private Black American Medical Practice."

William Dito, M.D., Pontiac,
conducted a seminar at Oakland University on "Chromosome Abnormalities," the opening session in a series of seminars developed for medical technologists.

Reuven Bar-Levav, M.D., Detroit,
is the 1968-69 president of the Wolverine State Group Phychotherapy Society, an affiliate Society of the American Group Psychotherapy Association.



MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW, EAST LANSING, MICHIGAN 48823

DIRECTORY OF MEMBERS

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY
VOLUME 67, NUMBER 23
PART TWO NOVEMBER 1968

12/10/68

Handy List of Some Often-Used Addresses:

Michigan State Medical Society
Headquarters: 120 West Saginaw, East Lansing 48823
Detroit Office: 1010 Antietam, Detroit 48207

American Medical Association
Headquarters: 535 N. Dearborn, Chicago 60610
Washington Office: 1 Farragut Square, South, Washington, D.C. 20006

Michigan Association of Regional Medical Plans, 1111 Michigan, East Lansing 48823
Albert E. Heustis, M.D., Executive Director

Michigan Council on Smoking and Health, 712 Abbott, East Lansing 48823
Ben Yep, Coordinator

Michigan Doctors Political Action Committee
P.O. Box 169, East Lansing 48823

Michigan Foundation for Medical and Health Education
120 West Saginaw, East Lansing 48823

Michigan Health Council, 712 Abbott Rd., East Lansing 48823
John A. Doherty, Executive Director

Michigan Hospital Service (Blue Cross), 441 E. Jefferson, Detroit 48226
Wm. S. McNary, President

Michigan Medical Service (Blue Shield), 441 E. Jefferson, Detroit 48226
John C. McCabe, President

State of Michigan:

Board of Basic Science, 1033 S. Washington Ave., Lansing 48933
Diane Stanislaw, Admin. Sec'y

Board of Registration in Medicine, 1033 S. Washington Ave., Lansing 48933
Luther R. Leader, M.D., Secretary

Department of Mental Health, Lewis Cass Bldg., Lansing 48913
William Anderson, M.D., Director

Department of Public Health, 3500 N. Logan, Lansing 48906
R. G. Rice, M.D., Acting Director

Department of Social Service, Lewis Cass Bldg., Lansing 48913
R. Bernard Houston, Director

MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

Members of the Michigan State Medical Society will find this 1969 issue of the Directory very useful. In addition to the several listings of the MSMS members, the Directory includes valuable reference information about the Michigan State Medical Society and its committees, the American Medical Association, etc.

The Publication Committee of The Council welcomes your suggestions.

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MICHIGAN STATE MEDICAL SOCIETY DIRECTORY

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This Directory lists the membership of each component medical society and therefore the total membership of the Michigan State Medical Society. For more effective reference use, the directory also contains an alphabetical list of all MSMS members, with a reference to both the page number and the county society code number.

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Guide to Help Locate Cities within the Counties

This guide matches up the counties for all Michigan communities of 1,000 population or more.*

CITY and COUNTY

Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Allen Park (Wayne)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)

Bad Axe (Huron)
Bangor (Van Buren)
Battle Creek (Calhoun)
Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)

CITY and COUNTY

Clawson (Oakland)
Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coloma (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Dearborn Heights, (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)
Gladwin (Gladwin)

CITY and COUNTY

Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores
(Wayne & Macomb)
Grosse Pointe Woods
(Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

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*See page 2 for Index by counties.

Guide to Help Locate Cities within the Counties/Continued

CITY and COUNTY

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Lathrup Village (Wayne)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore
(Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)
Niles (Berrien)
North Muskegon (Muskegon)

CITY and COUNTY

Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Orchard Lake (Oakland)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmet)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)

CITY and COUNTY

Sandusky (Sanilac)
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535 North Dearborn Street
Chicago, Illinois 60610
(312) 527-1500
(TWX-910-221-0300)
(ANS BK-AMA CGO)

1 Farragut Square, South
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Kirwin H. Stief, M.D., 115 Cass Avenue, Mt. Clemens 48043

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David A. Wild, M.D., 84 Cypress St., Manistee 49660

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Arnold L. Brown, M.D., 35 S. Johnson, Pontiac 48053
James A. Read, M.D., 610 N. Woodward, Birmingham 48011
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Peter A. Duhamel, M.D., 310 W. University, Rochester 48063
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Joseph E. Cooper, M.D., 417 W. Monroe St., Bangor 49013

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Stuart M. Gould, Jr., M.D., Box 65, Mercywood Hospital, Ann Arbor 48107
John E. Magielski, M.D., St. Joseph Mercy Hospital, Ann Arbor 48105
Clarence E. Crook, M.D., St. Joseph Mercy Hospital, Ann Arbor 48105
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Robert S. Ideson, II, M.D., 2200 Vinewood, Ann Arbor 48104
William R. Rekshan, M.D., 425 East Washington, Ann Arbor 48108
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Alexander Gotz, M.D., 2201 Medford Rd., Ann Arbor 48104

Neal A. Vanselow, M.D., Dept. of PG Med., University Hospital, Ann Arbor 48104

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Frank B. Bicknell, M.D., 938 Dav. Whitney Bldg., Detroit 48226
Brock E. Brush, M.D., 2799 W. Grand Blvd., Detroit 48202
James B. Blodgett, M.D., 76 W. Adams St., Detroit 48226
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Paul J. Connolly, M.D., 3800 Woodward Ave., Detroit 48201
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Raymond J. Barrett, M.D., 18280 Fairfield, Detroit 48221
Louis E. Heideman, M.D., 3800 Woodward Ave., Detroit 48001
Charles E. Darling, M.D., 673 Fisher Bldg., Detroit 48202
James M. Kennary, M.D., 4900 Cadieux Rd., Detroit 48224
C. Jackson France, M.D., 17800 E. Eight Mile Rd., Detroit 48236
Alexander Blain III, M.D., 2201 E. Jefferson, Detroit 48207
John G. Slevin, M.D., 1132 Whittier Ave., Grosse Pte. Park 48236
John W. Moses, M.D., Mt. Carmel Mercy Hospital, Detroit 48235
Robert H. Hamburg, M.D., 1515 David Whitney Bldg., Detroit 48226
Benjamin Jeffries, M.D., 19959 Vernier Rd., Harper Woods 48236
Ned I. Chalat, M.D., 1553 Woodward Ave., Detroit 48226
William J. Yott, M.D., 854 Lakeside Rd., Detroit 48236
William L. Brosius, M.D., 1823 Fairoak Ct., Rochester 48063
Alfred H. Whittaker, M.D., 3 Elmsleigh Lane, Grosse Pte. 48230
Loyal W. Jodar, M.D., 18412 Mack, Grosse Pte. 48236
Arthur B. Levant, M.D., 15715 E. Warren, Detroit 48224
Sidney E. Chapin, M.D., 125 N. Military, Dearborn 48124
Irvin A. Wilner, M.D., 17701 McNichols Rd., Detroit 48235
Robert D. Allaben, M.D., 18255 W. McNichols Rd., Detroit 48219
Eli J. Igna, M.D., 2799 W. Grand Blvd., Detroit 48202
Leon Rottenberg, M.D., 13419 Fenkell Ave., Detroit 48227
Alex H. Hirschfeld, M.D., 3790 Woodward, Detroit 48201
Harold V. Morley, M.D., 970 Fisher Bldg., Detroit 48202
Joseph A. Witter, M.D., 344 Glendale Ave., Highland Park 48203
Eugene L. Freitas, M.D., St. Johns Hospital, Detroit 48236
Homer A. Howes, M.D., 1515 David Whitney Bldg., Detroit 48226
H. Ross Hume, M.D., 3800 Woodward Ave., #406, Detroit 48201
Z. Stephen Bohn, M.D., 327 Professional Bldg., Detroit 48201
Harry Y. Kasabach, M.D., 1553 Woodward Ave., Detroit 48226
Reuben I. Shapiro, M.D., 22341 W. 8 Mile Rd., Detroit 48219
Thomas M. Flake, M.D., 13800 Livernois Ave., Detroit 48238
Fred E. Caumartin, M.D., 17184 Wildemere, Detroit 48221
Laurel S. Eno, 212 Eastland Professional Bldg., Detroit 48236
Walter F. Kujawski, M.D., 17800 E. 8 Mile Rd., Detroit 48236
Vincent J. Gallant, M.D., 16766 Ashton, Detroit 48219
Ralph H. Pino, M.D., 48151 W. Ann Arbor Rd., Plymouth 48170
Joseph O. Reed, Jr., M.D., 448 Lincoln, Detroit 48230
George Mogill, M.D., 3150 Second Blvd., Detroit 48201
Ernest L. Stefani, M.D., 18455 James Couzens Hwy., Detroit 48235
John W. Sigler, M.D., Henry Ford Hospital, Detroit 48202
Henry M. Domzalski, M.D., 15252 Gratiot Ave., Detroit 48205
Frank B. Walker II, M.D., 1206 Balfour Rd., Grosse Pte. Park 48230
Eugene T. Capuzzi, M.D., 24644 Gleneyrie Dr., Southfield 48075
Lee E. Feldkamp, M.D., 360 N. Main, Plymouth 48170
Paul R. Dumke, M.D., 2799 W. Grand Blvd., Detroit 48202
Elden C. Baumgarten, M.D., 1062 Lochmoor Blvd., Grosse Pte. Woods 48236
Carl J. Sprunk, M.D., 2900 Oakwood Blvd., Belvindale 48127
Marshall J. Blondy, M.D., 19009 W. 7 Mile Rd., Detroit 48219
Richard D. Anslow, M.D., 1515 Dav. Whitney Bldg., Detroit 48226
Lyle W. Korum, M.D., 18585 E. Warren St., Detroit 48236
Richard S. Kamil, M.D., 14438 McNichols, Detroit 48235
Thomas Genos, M.D., 6742 Park Ave., Allen Park 48101
Fredrick Weissman, M.D., 20905 Greenfield Rd., Southfield 48075
Charles J. Holt, Jr., M.D., 1210 S. Oxford, Grosse Pte. 48236
Robert A. Gerisch, M.D., 1217 Dav. Whitney Bldg., Detroit 48226
Walter L. Anderson, M.D., 1553 Woodward Ave., Detroit 48226
Carl A. Gagliardi, M.D., 3516 Fort St., Lincoln Park 48146
Robert C. Thumann, Jr., M.D., 20045 Mack Ave., Grosse Pte. Woods 48236
Louis R. Zako, M.D., 7720 Allen Rd., Allen Park 48101
John W. Moynihan, M.D., 2841 Monroe Blvd., Dearborn 48124
John F. Cotant, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Arthur A. Ulmer, M.D., 79 Greenbriar, Grosse Pte. Shores 48236
Earl E. Weston, M.D., 18101 Jas. Couzens Hwy., Detroit 48235
Michael N. Zelenock, M.D., 15830 Fort, Southgate 48192
Gerald H. Mandell, M.D., Sinai Hospital, Detroit 48235
Donald I. Bryan, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Robert E. McKnight, M.D., 15901 W. 9 Mile Rd., Southfield 48075
Everal M. Wakeman, M.D., 155 S. Denwood, Dearborn 48124
Horace F. Bradfield, M.D., 3008 E. Grand Blvd., Detroit 48202
Paul M. Zavell, M.D., 92 Moran Rd., Grosse Pte. Farms 48236
Andrew R. W. Climie, M.D., Harper Hospital, Detroit 48201
E. Clarkson Long, M.D., 19751 James Couzens Hwy., Detroit 48235
Arthur M. Clark, M.D., 401 River Lane, Dearborn 48124

Edward G. Forgrave, M.D., 18520 Grand River, Detroit 48219
Gilbert M. Bazil, M.D., 14200 Puritan, Detroit 48227
Alfred Golden, M.D., 26764 York Rd., Huntington Woods 48070
Raymond J. Kokowicz, M.D., 19440 Van Dyke, Detroit 48234
James R. Lloyd, M.D., 1515 Dav. Whitney Bldg., Detroit 48226
Laurence J. McNichol, M.D., 18424 W. McNichols Rd., Detroit 48219
John H. Williams, M.D., 18633 Mack Ave., Detroit 48236
Frank W. Prust, M.D., 1536 David Whitney Bldg., Detroit 48226
James P. Gallagher, M.D., 6535 Allen Rd., Allen Park 48101
N. Doyle McGlaughlin, M.D., 2312 Biddle Ave., Wyandotte 48192
Jean M. Holdredge, M.D., 3011 W. Grand Blvd., Detroit 48202
John M. Shuey, M.D., 17198 Oak Drive, Detroit 48221
John J. Siller, M.D., 17000 W. 8 Mile Rd., Southfield 48075
Kenneth J. Ray, M.D., 28059 Elba Drive, Grosse Ile 48138
Leonard W. Melander, Jr., M.D., 1229 Dav. Whitney Bldg., Detroit 48226
Victor E. Nelson, M.D., 3025 Crooks Rd., Royal Oak 48073
Robert B. Clarke, M.D., 76 W. Adams Ave., Detroit 48226
Charles P. Anderson, M.D., Dept. of Social Service, 640 Temple Ave., Detroit 48201

WEXFORD-MISSAUKEE

Dennis E. VanAlst, M.D., 828 Oak St., Cadillac 49601
Lawrence O. Garber, M.D., 222 Howard St., Cadillac 49601

SECTION DELEGATES

ALLERGY AND APPLIED IMMUNOLOGY

James A. McLean, M.D., 1313 E. Ann St., Ann Arbor 48103
Norman W. Brey, M.D., 1900 Broderick Tower, Detroit 48226

ANESTHESIOLOGY

Ralph F. Askam, M.D., Medical Arts Center, Muskegon 49440
Bernard Sivak, M.D., 24665 Santa Barbara, Southfield 48075

DERMATOLOGY

Robert J. Schoenfeld, M.D., 800 S. Adams Road, Birmingham 48011
Alternate not elected

GASTROENTEROLOGY

Irving A. Warren, M.D., 18984 Livernois, Detroit 48221
Alternate not elected

GENERAL PRACTICE

Douglas A. Haddock, Jr., M.D., 6646 Portage St., Kalamazoo 49002
James F. Dooley, M.D., 3210 S. Dort Hwy., Flint 48507

INTERNAL MEDICINE

Carl B. Beeman, M.D., 515 Lakeside Drive, S.E., Grand Rapids 49506
Bert M. Bullington, M.D., 2000 Court St., Saginaw 48602

NEUROLOGICAL SURGERY

H. Harvey Gass, M.D., 529 Fisher Bldg., Detroit 48202
Robert S. Knighton, M.D., 2799 W. Grand Blvd., Detroit 48211

OBSTETRICS-GYNECOLOGY

Howard R. Williams, M.D., 1950 Manchester Road, Ann Arbor 48104
Alternate not elected

OCCUPATIONAL MEDICINE

Benjamin B. Holder, M.D., Box 469, Midland 48640
Alternate not elected

OPHTHALMOLOGY

(*Not elected*)

OTOLARYNGOLOGY

G. Donald Albers, M.D., 203 Paris Ave., S.E., Grand Rapids 49503
Jordan C. Ringenberg, M.D., 50 S. College Ave., Grand Rapids 49503

ORTHOPEDIC SURGERY

John O. Goodsell, M.D., 1600 N. Michigan, Saginaw 48602
Perry W. Greene, M.D., 515 Lakeside Drive, S.E., Grand Rapids 49506

PATHOLOGY

John R. McDonald, M.D., Harper Hospital, Detroit 48201
Harold E. Bowman, M.D., 201 Lafayette S.E., Grand Rapids 49502

PEDIATRICS

George L. Blum, M.D., 18200 Wyoming, Detroit 48221
Alternate not elected

PHYSICAL MEDICINE

(*Not elected*)

PLASTIC SURGERY

Edward J. Hill, Jr., M.D., 949 David Whitney Bldg., Detroit 48226
Alternate not elected

PROCTOLOGY

Donald J. Pearson, M.D., 255 North Ave., Battle Creek 49017
Alternate not elected

PSYCHIATRY & NEUROLOGY

Robert B. Clarke, M.D., 76 W. Adams Ave., Detroit 48226
Warren S. Wille, M.D., 5325 Brown Lake Road, Jackson 49203

PUBLIC HEALTH & PREVENTIVE MEDICINE

G. Frederick Moench, M.D., 147 Center, Sanford 48657
Winston B. Prothro, M.D., 1619 Walker St., N.W., Grand Rapids 49504

RADIOLOGY

Benjamin R. VanZwalenburg, M.D., 2116 Coronado S.E., Grand Rapids 49506
Karl K. Latteier, M.D., 15025 W. 8 Mile Road, Detroit 48237

SURGERY

John W. Derr, M.D., 1145 David Whitney Bldg., Detroit 48226
Alternate not elected

THORACIC SURGERY

None

UROLOGY

Robert C. Thumann, M.D., 2004 Mack Ave., Grosse Pte. Woods 48236
James M. Pierce, Jr., M.D., Wayne State Univ., Detroit 48207

COMMITTEES OF THE SOCIETY

Appointed by MSMS President James J. Lightbody, M.D.

(Following are the names of the chairmen and vice-chairmen. The full committee lists are available from MSMS.)

ADVISORY COMMITTEE OF PAST OFFICERS (Presidents, Speakers, Council Chairmen)

B. M. Harris, MD, Chairman, 27 So. Prospect, Ypsilanti 48197

ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

G. E. Millard, MD, Chairman, 958 Fisher Building, Detroit 48202

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

M. R. Weed, MD, Chairman, 1059 Berkshire Road, Grosse Pte. Park 48230

COMMITTEE ON AGING

A. Hazen Price, MD, 18605 Birchcrest Drive, Detroit 48221

COMMITTEE ON BLOOD BANKS

L. W. Gardner, MD, Chairman, 6071 West Outer Drive, Detroit 48235

COMMITTEE ON CANCER

M. E. Dodds, MD, Chairman, 625 S. Grand Traverse, Flint 48503

COMMITTEE ON CARDIAC DISEASE CONTROL

S. E. Chapin, MD, Chairman, 125 N. Military, Dearborn 48124

COMMITTEE ON CHILD WELFARE

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COMMITTEE ON DIABETES

K. K. Vining, Jr., MD, Chairman, 515 Lakeside Drive, SE, Grand Rapids 49506

COMMITTEE ON GOVERNMENTAL MEDICAL CARE PROGRAMS

(Chairman to be appointed)

COMMITTEE ON HIGHWAY INJURIES

P. W. Gikas, MD, Chairman, 1900 Mershon, Ann Arbor 48103

COMMITTEE ON LEGAL AFFAIRS

Otto K. Engelke, MD, Chairman, 313 Washtenaw County Building, Ann Arbor 48108

P. T. Mulligan, MD, Vice Chairman, 612 Monitor Leader Building, Mt. Clemens 48043

COMMITTEE ON MATERNAL HEALTH

J. E. Harryman, MD, Chairman, 1200 Ransom Street, Muskegon 49442

L. B. Stevenson, MD, Vice Chairman, Henry Ford Hospital, Detroit 48202

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

D. K. Kessler, MD, Chairman, 540 Belvedere Drive, SE, Grand Rapids 49506

COMMITTEE ON MEDICINE AND OSTEOPATHY

J. J. Coury, MD, Chairman, 1209 Tenth Street, Port Huron 48060

COMMITTEE ON MENTAL HEALTH

Benjamin Jeffries, MD, Chairman, 19959 Vernier Road, Harper Woods 48236

E. H. Rodda, MD, Vice Chairman, 101 W. John Street, Bay City 48706

COMMITTEE ON OCCUPATIONAL HEALTH

William Jend, Jr., MD, Chairman, 1365 Cass Avenue, Detroit 48226

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

H. A. Towsley, MD, Chairman, W5610 University Hospital, Ann Arbor 48104

J. R. Heidenreich, MD, Vice Chairman, Daggett 49821

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

R. M. Stow, MD, Chairman, 2909 E. Grand River, Lansing 48912

COMMITTEE ON PUBLIC RELATIONS

B. E. Brush, MD, Chairman, 2799 W. Grand Blvd., Detroit 48202

COMMITTEE ON RESPIRATORY DISEASES

R. A. Rasmussen, MD, Chairman, 1810 Wealthy Street, SE, Grand Rapids 49501

COMMITTEE ON RURAL MEDICAL SERVICE

R. E. Rice, MD, Chairman, 420 S. Bower Street, Greenville 48838

COMMITTEES OF THE COUNCIL

Appointed by Council Chairman Ross V. Taylor, M.D.

(Following are the names of the chairmen and vice-chairmen. The full committee lists are available from MSMS.)

STANDING COMMITTEES

ADVISORY COMMITTEE TO EXECUTIVE DIRECTOR

R. V. Taylor, MD, Chairman, 756 W. Michigan, Jackson 49201

COUNTY SOCIETIES COMMITTEE

J. J. Coury, MD, Chairman, 1209 Tenth Street, Port Huron 48060

EDUCATION LIAISON COMMITTEE

Milton R. Weed, MD, Chairman, 1059 Berkshire Road, Grosse Pte. Park 48230

FINANCE COMMITTEE

R. K. Whiteley, MD, Chairman, 608 Eastland Center Professional Bldg., Detroit 48236

PUBLICATION COMMITTEE

B. L. Masters, MD, Chairman, 111 W. Dayton Street, Fremont 49412

* * *

LIAISON COMMITTEES

LIAISON WITH MICHIGAN HOSPITAL SERVICE

R. R. Cooper, MD, 1515 David Whitney Building, Detroit 48226

J. J. Lightbody, MD, 7815 E. Jefferson, Detroit 48214

R. V. Taylor, MD, 756 W. Michigan, Jackson 49201

LIAISON WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

H. C. Hansen, MD, Chairman, 417 Post Building, Battle Creek 49014

LIAISON WITH MICHIGAN WELFARE LEAGUE

B. M. Harris, MD, 27 So. Prospect, Ypsilanti 48917

B. L. Masters, MD, 111 W. Dayton Street, Fremont 49412

C. Allen Payne, MD, 1840 Wealthy Street, SE, Grand Rapids 49506

Otto K. Engelke, MD, Advisor, 313 Washtenaw County Building, Ann Arbor 48108

LIAISON WITH PODIATRY

Wm. H. Blodgett, MD, Chairman, 76 West Adams Street, Detroit 48226

LIAISON WITH RESIDENTS, INTERNS, SENIOR MEDICAL STUDENTS

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LIAISON WITH STATE BAR OF MICHIGAN

O. J. Johnson, MD, Chairman, 207 N. Walnut, Bay City 48706

LIAISON WITH STATE BOARD OF REGISTRATION IN MEDICINE

O. J. Johnson, MD, Chairman, 207 N. Walnut, Bay City 48706

LIAISON WITH STATE EXECUTIVE OFFICE

K. H. Johnson, MD, Chairman, 1116 Michigan National Tower, Lansing 48933

LIAISON WITH MICHIGAN CHAPTER, HEALTH INSURANCE COUNCIL

B. E. Brush, MD, 2799 W. Grand Blvd., Detroit 48202

J. J. Coury, MD, 1209 Tenth Street, Port Huron 48060

Otto K. Engelke, MD, 313 Washtenaw County Bldg., Ann Arbor 48108

D. L. Kessler, MD, 540 Belvedere Drive, SE, Grand Rapids 49506

* * *

OTHER COMMITTEES

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE

H. A. Raskin, MD, Chairman, 18510 Meyers Road, Detroit 48235

COMMITTEE ON AWARDS

C. Allen Payne, MD, Chairman, 1840 Wealthy Street, SE, Grand Rapids 49506

COMMITTEE ON BEAUMONT MEMORIAL

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Otto O. Beck, MD, Honorary Chairman, 308 Wabeek Building, Birmingham 48011

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

R. O. Kraft, MD, Chairman, 2355 E. Stadium Blvd., Ann Arbor 48104

H. A. Towsley, MD, Vice Chairman, W5610 University Hospital, Ann Arbor 48104

A. J. Walt, MD, Vice Chairman, Detroit Receiving Hospital, Detroit 48226

COMMITTEE ON EMERGENCY AND DISASTER MEDICAL SERVICES

C. P. Anderson, MD, Chairman, 640 Temple Avenue, Detroit 48201

COMMITTEE ON EYE CARE

R. T. Blackhurst, MD, Chairman, 233 E. Larkin, Midland 48640

COMMITTEE ON HOSPITAL RELATIONS

A. C. Stander, MD, Chairman, 1411 Court Street, Saginaw 48602

COMMITTEE ON INTERNATIONAL HEALTH

H. A. Branch, MD, Chairman, 817 Mott Foundation Bldg., Flint 48502

COMMITTEE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS

G. A. O'Connor, MD, Chairman, University of Michigan Medical Center, Ann Arbor 48104

COMMITEE ON MEDICINE AND RELIGION

W. G. Fox, MD, Chairman, 715 N. University, Ann Arbor 48104

COMMITTEE ON MICHIGAN MEDICAL HISTORY

J. R. G. Gosling, MD, Chairman, 315 Corrie Road, Ann Arbor 48105

COMMITTEE ON NURSING

R. L. Tupper, MD, Chairman, 86 Ottawa Drive, Pontiac 48053

COMMITTEE ON REHABILITATION

(Chairman to be appointed)

COMMITTEE ON RELATIVE VALUE STUDY

(Chairman to be appointed)

COMMITTEE TO STUDY HEALTH PROBLEMS OF THE DISADVANTAGED IN THE CITIES

F. B. Walker, MD, Chairman, 1206 Balfour Road, Grosse Pte. 48230

COMMITTEE TO MEET WITH MEDICAL SPECIALTY GROUPS

C. Allen Payne, MD, Chairman, 1840 Wealthy Street, SE, Grand Rapids 49506

COMMITTEE ON ORTHODONTICS

R. O. Dingman, MD, Chairman, 221 N. Ingalls, Ann Arbor 48104

COMMITTEE ON QUACKERY

J. N. Schaeffer, MD, Chairman, 261 Brady, Detroit 48201

Directory, Listed by Component Medical Societies

Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; "O" for Osteopathic Associate Members; all others are Active Members (Numbers in parentheses indicate County Society Code Numbers used in Alphabetical Roster.)

ALLEGAN COUNTY MEDICAL SOCIETY (10)

Brachman, A. Peter, Jr...222 Trowbridge St., Allegan 49010
Brown, Lewis F. (R)...451 W. Allegan St., Otsego 49078
Chase, Walter E........137½ N. Main St., Plainwell 49080
Clark, James I..................Box B, Fennville 49408
Everett, D. W.......Plainwell Sanitarium, Plainwell 49080
Goddard, G. B..............218 E. Orleans, Otsego 49078
Goude, Albert G. (A)
Hays, James D.........................Douglas 49406
Johnson, Elwin B...........412 Water St., Allegan 49010
Johnson, Harrison H. (L)...............Wayland 49348
Keeler, Van O. ....304 Dix St., Otsego 49078
Mahan, James E.......402 Trowbridge St., Allegan 49010
Medill, Wilbur C. (R)...139 N. Main St., Plainwell 49080
Miller, Kenneth C....................Saugatuck 49453
Plogenhoef, Richard...........304 Dix St., Otsego 49078
Pone, Janis.............................Martin 49070
Ramseyer, Gladwin E......125 E. Bridge, Plainwell 49080
Schneiter, Harry E.........425 Cutler St., Allegan 49010
Schock, William H........315 Maple St., Saugatuck 49453
Southern, Edward.......................Allegan 49010
Topp, E. Robert..........500 Allegan St., Plainwell 49080
Topp, Elwin W...........353 Naomi St., Plainwell 49080
Van Der Kolk, Bert....................Hopkins 49328
Vandervoord, Gerald....312 E. Plum St., Wayland 49348
Vaughan, Willard R. (L)..............Plainwell 49080
Wiseman, Bertha A...............Box 177, Allegan 49010

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

Aliferis, Peter........Alpena General Hosp., Alpena 49707
Arscott, Edward F...................Rogers City 49779
Brown, Donald C......312 E. Chisholm St., Alpena 49707
Bunting, John W..........110 N. 1st Ave., Alpena 49707
Burkholder, H. J. (L)..122 N. Second Ave., Alpena 49707
Cohn, Stuart L.......1253 W. Washington, Alpena 49707
Constantine, Aeneas...................Harrisville 48740
Cook, Thomas J.......312 E. Chisholm St., Alpena 49707
Finch, Donald E.......................Onaway 49765
Foley, Richard.....................Rogers City 49779
Fox, William L.......601 W. Chisholm St., Alpena 49707
Grause, Thomas J.....312 E. Chisholm St., Alpena 49707
Greenwood, James........115 N. First St., Alpena 49707
Guner, Ali.......Alpena General Hospital, Alpena 49707
Hier, Edward A.......125 N. Second Ave., Alpena 49707
Jackson, Wm. F...............RFD 1, Huron Shore Dr., Rogers City 49779
Kutsche, W. F...............208 Lake St., Oscoda 48753
Leopard, J. M............312 E. Chisholm, Alpena 49707
Nesbitt, Wm. E...........123 N. 2nd Ave., Alpena 49707
Newman, Roy E.....Alpena General Hosp., Alpena 49707
O'Dell, F. C., Jr.......110 W. Chisholm St., Alpena 49707
Parmenter, Elbert S. (L)..316 W. Third, Dixon, Ill. 61021
Ramsey, J. A.............312 E. Chisholm, Alpena 49707
Ries, Robt. C.....573 N. Bradley Hwy., Rogers City 49779
Riker, John L.........601 N. Second Ave., Alpena 49707
Spens, James E........123 N. Second Ave., Alpena 49707
Stibitz, Henry B.......1065 US 23 North, Alpena 49707
Stump, G. D...............113 State Ave., Alpena 49707
Wagoner, Darwin E............5007 N. Cedar Lake Rd., Oscoda 48753
Watkins, T. M.........312 E. Chisholm St., Alpena 49707
Wienczewski, T. W.......919 N. 2nd Ave., Alpena 49707
Wilson, Chas. S. (L).......730 State Ave., Alpena 49707

BARRY COUNTY MEDICAL SOCIETY (18)

Blair, Larry..............110 W. Center, Hastings 49058
Brown, Jack A..............535 Francis, Hastings 49058
Castleman, Douglas H....146 E. State St., Hastings 49058
Finnie, Gordon M.......Pennock Hospital, Hastings 49058
Finnie, Raymond G. (A)..535 E. Francis, Hastings 49058
Gwinn, Alexander B. (L)........1016 San Lucia Dr. SE, Grand Rapids 49506
Heaslip, Jos. D. (R).............13800 83rd Place N., Largo, Florida 33540
Hoffs, Marinus A.......911 Fourth St., Lake Odessa 48849
Huebner, R. J............110 W. Center, Hastings 49058
Lofdahl, Stewart (R) R. 1, Box 172, St. Charles, Ill. 60174
Logan, Wesley G........City Bank Bldg., Hastings 49058
Lundeen, John G.....................P.O. Box 2213 B, Port Au Prince, Haiti B.W.I.
Morrill, Charles E......110 W. Center St., Hastings 49058
Myers, Thos. W.........307 N. Main St., Nashville 49073
Noah, Melvin L.....................Middleville 49333
Phelps, Everett L. (A)..535 E. Francis St., Hastings 49058
Pryor, Robt. B...........400 W. State St., Hastings 49058
Spindler, James R......110 W. Center St., Hastings 49058
Tromp, Jack L.............R. D. 3, Lake Odessa 48849

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A.........1420 Center Ave., Bay City 48706
Alcorn, Marshall W.....1420 Center Ave., Bay City 48706
Alis, Asim K.........1803 Borton Ave., Essexville 48732
Allen, Arthur D. (L)....101 W. John St., Bay City 48706
Antle, Robert C..........101 W. John St., Bay City 48706
Asbury, Richard B.........2110 16th St., Bay City 48706
Asline, John N........207 N. Walnut St., Bay City 48706
Austin, Justus J. (R)..................Tawas City 48763
Bickham, Richard E......101 W. John St., Bay City 48706
Bowman, David A...............1815 Wm. H. Taft Rd., Cincinnati, Ohio 45206
Bozdech, Jiri Josef.......900 N. Jackson, Bay City 48706
Brenner, Frederick......1805 Sixth Street, Bay City 48706
Brinkman, Harvey H...116 W. State St., East Tawas 48730
Brown, Geo. M. (L)...207 N. Walnut St., Bay City 48706
Buechle, George T...............175 E. Pinconning Dr., Pinconning 48650
Cajigas, Tomas R....1908 Columbus Ave., Bay City 48706
Campbell, Donald A.........700 Borton, Essexville 48732
Campbell, John S...2107 Sixteenth Street, Bay City 48706
Chapin, Fredk. J......State Hospital, Traverse City 49684
Cook, Hugh K...........101 W. John St., Bay City 48706
Cook, Raymond R.......1115 Fifth Street, Bay City 48706
Cooper, James C...........410 Hart St., Essexville 48732
Cosens, Stanley A........101 W. John St., Bay City 48706
Crissey, Robt. R.........101 W. John St., Bay City 48706
Criswell, Robt. H. (L)........3419 Portage Blvd., #43, Fort Wayne, Ind. 46804
Csonka, Nicholas....1308 Columbus Ave., Bay City 48706
Dardas, Michael J......1413 Center Ave., Bay City 48706
Davis, James H..........1308 Columbus, Bay City 48706
Dolbee, Malcolm K.............Box 518, Standish 48658
Ferguson, Robert........101 W. John St., Bay City 48706
Fischer, Hans...........................Standish 48658
Follis, Wm. M.............101 W. John, Bay City 48706
Gamble, Wm. G., Jr. (L)..2010 5th Ave., Bay City 48706
Gehman, J. R............................Standish 48658
Geneczko, John T....1308 Columbus Ave., Bay City 48706
Grigg, John W.........2110 Sixteenth St., Bay City 48706
Gueramy, Mono........1411 Center Ave., Bay City 48706
Hafford, Robert C........101 W. John St., Bay City 48706
Hagelshaw, Gayland L....101 W. John St., Bay City 48706
Heuser, Harold H...916 Washington Ave., Bay City 48706
Horowitz, Saml. F......1415 Center Ave., Bay City 48706
Howland, Walter L......2110 E. 16th St., Bay City 48706
Jacques, J. E.........................Tawas City 48763
Jaffe, Martin D..........2110 16th Street, Bay City 48706
Jens, Otto F. (L)....................Essexville 48732
Johnson, Orlen J. (L)..207 N. Walnut St., Bay City 48706
Jones, M. Culver........900 N. Jackson, Bay City 48706
Jones, Tyre K., III (M).............102 N.W. 33rd St., Mineral Wells, Texas 76067
Kelly, Larry Stanley..................Tawas City 48763
Kessler, Mana (L)......311 Center Ave., Bay City 48706
Kessler-Frux, Sabina (L).311 Center Ave., Bay City 48706
Knobloch, Howard T.....1102 Columbus, Bay City 48706
Kovacsi, Laszlo..........820 N. Johnson, Bay City 48706
Kulinski, Eugene J.........2110 16th St., Bay City 48706
Lambert, Leslie A. (R)..........R 1, East Tawas 48730
Langin, John L.............100 15th St., Bay City 48706
Loan, G. B........Essexville Mdcl. Bldg., Essexville 48732
Loree, Joseph..........1407 Center Ave., Bay City 48706
MacRae, Leonard D.....813 Sherman St., Bay City 48706
Mayne, John C..........101 W. John St., Bay City 48706
McGee, Harry B...........101 W. John, Bay City 48706
McGee, Peter L...........2110 16th St., Bay City 48706
McSherry, Leo B., Jr..1308 Columbus Ave., Bay City 48706
Medvezky, Michael J. (R)........1106 S. Madison Ave., Bay City 48706
Miller, Edwin C.........101 W. John St., Bay City 48706
Moeller, Arlyn..........700 Borton Ave., Essexville 48732
Moore, Allen B.........700 Borton Ave., Essexville 48732
Moore, Neal R............2138 Fifth St., Bay City 48706
Mosier, Dwight J.........101 W. John St., Bay City 48706
Parks, Floyd R., Jr.......101 W. John St., Bay City 48706
Payea, Norman P.....217 Newman St., East Tawas 48730
Pearson, Stanley M.......101 W. John St., Bay City 48706
Pederson, B. L........East Medical Bldg., Bay City 48706
Pelczar, Walter E..........2786 Oak Place, Bay City 48706
Prophater, Robt. C....202 Boehringer Ct., Bay City 48706
Reidinger, Alan A. (M)..4307 Elmwood, Royal Oak 48073
Rodda, E. H............101 W. John St., Bay City 48706
Rowe, Paul W...........Mercy Hospital, Bay City 48706
Salman, Feyyaz.......1221 Orchard Rd., Essevxille 48732
Schmelzer, Wm. J.............602 Mercer St., P.O. 746, Pinconning 48650
Shafer, Harold C........101 W. John St., Bay City 48706
Shields, Hubert L.......101 W. John St., Bay City 48706
Standiford, David.........2110 16th St., Bay City 48706
Stroia, Livius N.........101 W. John St., Bay City 48706
Sutton, R. L., Jr......116 W. State St., East Tawas 48730
Taheri, Zia E........1411 Center Avenue, Bay City 48706
Tarter, Clyde S. (R)...........Star Route, Alpena 49707
Tompkins, Dana A....................Pinconning 48650
Treadway, Gaylord.......900 N. Jackson, Bay City 48706
Vail, Harry F.......564 W. Hampton Rd., Essexville 48732
Vanasupa, P............101 W. John St., Bay City 48706
Way, John H. (M)..............Med. Center, Okinawa, APO San Francisco, California 96331
Wilson, Thos. G. (R)..R. 2, Box 112H, Tawas City 48763
Woodburne, Harris L.....1420 Center St., Bay City 48706
Wright, Thomas B.......101 W. John St., Bay City 48706
Ziliak, Alois L. Jr...3347 Highland Woods, Bay City 48706

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R.......2817 S. State St., St. Joseph 49085
Atkinson, Robert L...2821 S. State Street, St. Joseph 49085
Bailey, John H...2150 Samuel Ave., Benton Harbor 49022
Beal, Gerald N...Sheperd Benning Bldg., St. Joseph 49085
Benner, Wm. H..960 Agard St. Lab., Benton Harbor 49022
Bhisitkul, Iam P............1 South 5th St., Niles 49120
Bieri, Dixon L....645 Riverview Dr., Benton Harbor 49022
Bliesmer, August F.....505 Pleasant St., St. Joseph 49085
Bock, William C.....505 Pleasant Street, St. Joseph 49085
Brink, John W...........807 Myrtle St., St. Joseph 49085
Bronfenbrenner, Jack...............687 E. Empire Ave., Benton Harbor 49022
Bruni, John R..............1 South Fifth St., Niles 49120
Bunker, Frank H...858 Pipestone St., Benton Harbor 49022
Cadieux, Hale W. 645 Riverview Dr., Benton Harbor 49022
Camp, Donald C.........8 N. St. Joseph Ave., Niles 49120
Carter, John H.................687 E. Empire Avenue, Benton Harbor 49022
Cawthorne, Harold J. (R)...R. 4, Box 201, Coloma 49038
Chickering, Wm. A.....2016 Lakeview, St. Joseph 49085
Cilella, S. G.............Pawating Hospital, Niles 49120
Colligan, Joseph (A) University Hospital, Ann Arbor 48104
Conway, Jos..............358 N. Main, Watervliet 49098
Conybeare, Robt. C...756 Pipestone, Benton Harbor 49022
Cooke, Weldon..................Berrien General Hosp., Berrien Center 49102
Cooper, Wm. L.............Rt. 4, Box 78, Coloma 49038
Crowell, Richard C....................645 Riverview Dr., Benton Harbor 49022
Dailey, Walter S..............122 Grant St., Niles 49120
Dalgleish, Archie J.....460 N. Main St., Watervliet 49098
Doolittle, John E.....9 S. St. Joseph Avenue, Niles 49120
Eidson, Hazel D. (L).............Berrien Springs 49103
Elghammer, Richard M...............1850 Colfax Ave., Benton Harbor 49022
Emery, Clayton S. (L)..1329 Lake Blvd., St. Joseph 49085
Emery, Wm. K.........1020 Niles Ave., St. Joseph 49085
Faber, Michael....756 Pipestone St., Benton Harbor 49022
Fattic, Grover R., Jr.....61 N. St. Joseph Ave., Niles 49120
Feeley, Marshall J......2516 Niles Ave., St. Joseph 49085
Friedman, Morris E.................115 N. Barton St., New Buffalo 49117
Galles, James O........429 Paw Paw Ave., Coloma 49038
Gillette, Clarence (L).....RFD 4, M-60 W, Niles 49120
Gould, Samuel H...1850 Colfax Ave., Benton Harbor 49022
Grayson, Chas. J..........4 Maple St., Three Oaks 49128

Green, Barbara G. . .2600 Morton Street, St. Joseph 49085
Green, Robt. L. . . . . . .2600 Morton Street, St. Joseph 49085
Grundset, Harold M. . . .61 N. St. Joseph Ave., Niles 49120
Guaty, Nestor C. . .858 Pipestone St., Benton Harbor 49022
Gustin, Ralph D. . . . .P.O. Box 159, Berrien Springs 49103
Haight, Arthur S. 645 Riverview Dr., Benton Harbor 49022
Hassan, D. Kent. . . . . . . .802 E. Front St., Buchanan 49107
Haupt, Edward C. . .687 E. Empire, Benton Harbor 49022
Hayes, Thos. P. (A). . . . . .Univ. of Pa. Grad Hosp., 19th and Lombard, Philadelphia, Pa. 19146
Henderson, Fred C. . . . . .703 E. Main, Niles 49120
Hershey, Noel J. . . . . .P.O. Box 222, Niles 49120
Hills, David W. . . . . .2821 State St., St. Joseph 49085
Howard, Frank W. . . .756 Pipestone, Benton Harbor 49022
Hudnutt, Dean. . . . . .807 Myrtle St., St. Joseph 49085
Huff, Harold D. . . . . .126 Main St., Niles 49120
Irgens, Edwin R. 11 Peoples St. Bk. Bldg., St. Joseph 49085
Johnston, Wm. H. . . . . . . .715 Market St., St. Joseph 49085
Kelsall, Harvey I. . . . . . . .1600 Niles Ave., St. Joseph 49085
Kennedy, F. Alan 315 Fidelity Bldg., Benton Harbor 49022
Kilic, Orhan. . . . . .8 N. St. Joseph St., Niles 49120
King, Frank A., Jr. . . .858 Pipestone, Benton Harbor 49022
Klos, Henry J. . . . . . . .2700 Highland Ct., St. Joseph 49085
Koh, Nan Kyung. . . . . .Berrien Co. Health Dept., St. Joseph 49085
Landgraf, Robt. L. . . . . .P.O. Box 222, Niles 49120
Lanting, Helen E. P. . . . .2002 State St., St. Joseph 49085
Learned, David W. . . . . .645 Riverview Dr., Benton Harbor 49022
Lee, Hai Soon. . . . . . . .711 Beechwood Drive, Niles 49120
Leva, John B. . . . . .1122 Salem Ave., Benton Harbor 49022
Lindenfeld, Fredk. H. . . .8 N. St. Joseph Ave., Niles 49120
Lininger, Richard E. . .2712 Highland Ct., St. Joseph 49085
Linn, Frank. . . . . .2522 Niles, St. Joseph 49085
Maddock, Gene E. . . . . .Mercy Hosp. X-Ray Dept., Benton Harbor 49022
Manning, John T. . . . .2817 So. State St., St. Joseph 49085
McDonald, James L. . . . .2516 Niles Ave., St. Joseph 49085
McLelland, J. T. . . . . .Mercy Hosp. X-ray Dept., Benton Harbor 49022
Mesirow, Stanley M. . . . . .687 E. Empire Ave., Benton Harbor 49022
Moore, T. Scott. . . . . .P.O. Box 416, Niles 49120
Namtze, Chan. . . . . .302 Broadway, Niles 49120
O'Toole, John. . . . . . .133 E. Napier, Benton Harbor 49022
Ozeran, Chas. J. . . . . .127 E. Napier, Benton Harbor 49022
Padelford, Wm. J. . .206 Whipple Blvd., South Lyon 48178
Payne, Charles E. . .925 Pipestone St., Benton Harbor 49022
Peshka, David K. . . . . . .61 N. St. Joseph Ave., Niles 49120
Polansky, Sanford. . .84 W. Main St., Benton Harbor 49022
Porter, Chas. B. . .1589 Colfax Ave., Benton Harbor 49022
Quadir, Michael Syed. . . . . .P.O. Box 326, Fennville 49408
Rambo, Joseph J. . . . . .555 Lake St., Bridgman 49106
Ray, Dean K. . . . . .2522 Niles, St. Joseph 49085
Reagan, Robt. E. . . . . . .232 Windsor, Benton Harbor 49022
Rizzo, Albert. . . . . .2912 S. State St., St. Joseph 49085
Rooks, J. F. Girard. . .2002 S. State St., St. Joseph 49085
Ruth, J. Griswold. .1304 Seneca Rd., Benton Harbor 49022
Skinner, James W. . . . .460 Ridgeway St., St. Joseph 49085
Smith, W. B. . . . . .133 E. Napier, Benton Harbor 49022
Sori, Manuel R. . . .858 Pipestone St., Benton Harbor 49022
Sowers, Bouton F. .236 Higman Park, Benton Harbor 49022
Strayer, John W. . . . . .P.O. Box 222, Niles 49120
Sutherland, Burton M. . . . . .Berrien Gen. Hosp., Berrien Center 49102
Turner, John J. . . . . .2817 S. State St., St. Joseph 49085
Urist, Maurice D. . .454 Pipestone St., Benton Harbor 49022
Valantiejus, John A. . . . . .R.R. 2, Cedar Lane Farm, New Buffalo 49117
Vasquez, Andres H. . . .11 E. Merchant, New Buffalo 49117
Vastine, Russell J., Jr. . . .430 W. Chicago, Buchanan 49107
Westervelt, H. O. (L). .539 Pearl St., Benton Harbor 49022
Willson, Dean. . . . . . . .756 Pipestone, Benton Harbor 49022
Wilson, Clinton W. 925 Pipestone St., Benton Harbor 49022
Wise, Warren A. . . . . . .505 Pleasant St., St. Joseph 49085
Woodford, Hackley E. . .599 E. Main, Benton Harbor 49022
Zick, Luther H. . . . . .2522 Niles Ave., St. Joseph 49085

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S. . . . . . .162 Marshall St., Coldwater 49036
Bacon, Charles R. . . . .300 E. Chicago St., Coldwater 49036
Bailey, James E., Jr. . .300 E. Chicago St., Coldwater 49036
Beatty, James B. . . . .206 Coffee St., Russellville, Ala. 35653
Burke, James M. . . . . .R. 4, Coldwater 49036
Coates, Carl A. . . .135 Stringtown, R.F.D. 1, Quincy 49082
Culver, Dean T. . . . . .173 E. Chicago St., Coldwater 49036
Fraser, Robt. J. . . . . .52 Fairfield Dr., Coldwater 49036
Geib, Ormond D. . . . . .133 Walnut Blvd., Rochester 48063
Gift, Jack. . . . . .274 E. Chicago St., Coldwater 49036
Gomley, Henry C. . . . . .108 E. Chicago St., Bronson 49028
Heffelfinger, John C. . . . . .292 E. Chicago Ave., Coldwater 49036
Hoeksema, Ronald H. 292 E. Chicago St., Coldwater 49036
Leitch, Robt. M. . . . . .401 Ann St., Union City 49094
Meier, Harold J. (L) . . . .87 W. Pearl St., Coldwater 49036
Mooi, Henry R. . . . . . .292 E. Chicago St., Coldwater 49036
Moss, Harvey L. . . . . .47 Carlyle, Coldwater 49036
Nettleman, Wm. E. . . . . .87 W. Pearl St., Coldwater 49036
Olmsted, Kenneth L. . . . . .675 Monroe, Coldwater 49036
Rennell, Edwin J. Coldwater State Home, Coldwater 49036
Rick, John J. . . . . .61 E. Chicago St., Coldwater 49036
Schillinger, H. K. . . . . .Box 148, Coldwater 49036
Stewart, William K. . . . . . . .403 Ann St., Union City 49094
Thomas, James A. . . . .390 E. Chicago St., Coldwater 49036
Valderrama, F. P. . . . . . .235 E. Chicago, Coldwater 49036
Walton, Nathaniel J. . . . . .Box 148, Coldwater 49036
Weidner, Harold R. . . . . .50 Division St., Coldwater 49036
Wise, Robert. .State Hm. & Trng. School, Coldwater 49036

CALHOUN COUNTY MEDICAL SOCIETY (34)

Albright, Arnold A. . . . . .R. 1, Box 300, Battle Creek 49014
Allen, R. H. . . . . .191 College, Battle Creek 49017
Amlicke, James. . . .191 College Street, Battle Creek 49017
Amos, Norman H. (R) . . . . .710 North Avenue, Battle Creek 49017
Amos, Norman O. . .710 North Avenue, Battle Creek 49017
Anderson, Harold E. . . . . .501 Post Building, Battle Creek 49017
Azuela, Victor. . . .124 Lakeview Ave., Battle Creek 49015
Baker, James E. (A) . . .VA Hospital, Battle Creek 49016
Bakken, Richard L. . . .200 College St., Battle Creek 49017
Barden, Stuart P. . . . . .Leila Hosp., Battle Creek 49014
Baribeau, Roy H. (L). .531 Post Bldg., Battle Creek 49017
Bartels, George H. . .710 North Avenue, Battle Creek 49017
Becker, Harry F. (L) . . . . .Box 547, Battle Creek
Berghorst, John (A) . . . . .89 S. Lavista Blvd., Battle Creek 49015
Bonifer, Philip P. . . . . .231 North Ave., Battle Creek 49017
Bonifer, Philip P., Jr. . . . . .401 Security Bk. Bldg., Battle Creek 49014
Boswell, David E. . . .105 N. Jefferson Ave., Marshall 49068
Brown, Robt. W. . . .231 North Avenue, Battle Creek 49017
Buell, Martin F. (A) . . . .V. A. Hospital, Ft. Custer 49016
Byrnes, Allen W. . .76 W. Minges Rd., Battle Creek 49015
Campbell, Alice F. . . . . . .103 E. Mulberry St., Albion 49224
Campbell, Richard J. (R) 154 West St., Battle Creek 49017
Canlas, Marcelo. . . . . .Leila Hosp., 9 Emmett Street, Battle Creek 49016
Capron, M. J., Jr. . . . . .806 Security Bk. Bldg., Battle Creek 49014
Caviness, L. Harold. . . . . .185 N. Washington, Battle Creek 49017

Chandler, Edward M..........411 Mich. Nat. Bk. Bldg., Battle Creek 49014
Chynoweth, Wm. R. (L)...............207 Post Bldg., Battle Creek 49017
Coakes, Jack E. (A)......716 Gorham St., Marshall 49068
Colquhoun, Graham F. 188 College St., Battle Creek 49017
Comai, William B.................110 Shadywood Lane, Battle Creek 49015
Cram, Ralph A...........500 S. Ionia St., Albion 49224
Curry, Robt. K.........................Homer 49245
Daly, Harold L., Jr.........500 S. Ionia St., Albion 49224
Daly, Mary........................Box 7, Albion 49224
Daly, Miriam S............500 S. Ionia St., Albion 49224
Diamante, Paul J...710 North Avenue, Battle Creek 49017
Dickson, Albert R. (L).............250 Champion St., Battle Creek 49017
Dodge, Warren M., Jr. (R).............75 Laurel Dr., Battle Creek 49017
Fairbanks, Stephen (R)................Wellston 49689
Ferazzi, Patrick S....1018 North Ave., Battle Creek 49017
Finch, Duward L.................719 Capital Ave. SW., Battle Creek 49015
Fisher, Robt. E.................1501 W. Michigan Ave., Battle Creek 49017
Fraser, Robt. H. (L)..........1112 Security Bk. Bldg., Battle Creek 49014
Funk, L. D.............133 W. Burr Oak, Athens 49011
Giddings, A. M. (L) Battle Creek San., Battle Creek 49017
Cieser, E. Paul, Jr........188 College, Battle Creek 49017
Cilfillan, Margery J. (L).............125 56th Ave S., St. Petersburg, Fl. 33708
Girardot, John G.....25 W. Michigan, Battle Creek 49014
Glotfelty, Philip R.....219 N. Madison St., Marshall 49068
Gough, Joseph G...............American Legion Hosp., Battle Creek 49014
Graubner, Franklin L. Bogar Theater Bldg., Marshall 49068
Gray, J. Alan................309 Mich. Natl. Bk. Bldg., Battle Creek 49014
Green, Harold E......175 College St., Battle Creek 49017
Griffith, Jack C..............616 Mich. Nat. Bnk. Bidg., Battle Creek 49014
Halac, Mehmet E.....163 North Ave., Battle Creek 49017
Hamady, Alfred.....1018 North Ave., Battle Creek 49017
Hansen, Harvey C...............65 W. Michigan Ave., Battle Creek 49014
Henderson, Philip M..........109 W. Erie, Albion 49224
Henriksen, J. D..........4 Hiawatha, Battle Creek 49015
Hibbs, Donald K....................777 S.E. Second, Deerfield Beach, Fla. 33441
Hickman, Marjorie J. (A)............1018 North Ave., Battle Creek 49017
Higgins, C. C.......710 North Ave., Battle Creek 49017
Hollis, Gabriel D. 124 Lakeview Ave., Battle Creek 49015
Holtom, Benj. C...815 Security Tower, Battle Creek 49014
Hooker, Lyle T. (A)....V.A. Hospital, Battle Creek 49016
Hubly, James W..................777 SE Seeond Ave., Deerfield Beach, Fl. 33441
Humphrey, Archie E...122 N. Madison St., Marshall 49068
Humphrey, Arthur A...175 College St., Battle Creek 49017
Humphrey, Herbert E. 122 N. Madison St., Marshall 49068
Huntington, John.....710 North Ave., Battle Creek 49017
Jacobson, Dwight................411 Mich. Natl. Bank, Battle Creek 49014
Jeffrey, James R. (L)..........197 N. Washington Ave., Battle Creek 49017
Johnson, Melvin, Jr.....Leila Hospital, Battle Creek 49014
Jones, Aubrey H. (A)............513 W. Michigan Ave., Marshall 49068
Jones, Ernest F. (A)..175 Island Ave., Battle Creek 49017
Jones, Tyre K.............118 W. Green, Marshall 49068
Kelleher, George T....235 North Ave., Battle Creek 49017
Kinde, Matthew R. (A).250 Champion, Battle Creek 49017
Kingsley, Paul C.........191 College, Battle Creek 49017
Klopp, Edward J.......173 College St., Battle Creek 49017
Lakke, Gordon W...710 North Avenue, Battle Creek 49017
Lam, Francis L...408 Capital Ave. SW, Battle Creek 49015
Lancaster, Vance B....710 North Ave., Battle Creek 49017
Lanuti, Frank.......1018 North Ave., Battle Creek 49017
Levy, Jos., Jr........231 North Ave., Battle Creek 49017
Lewis, Welcome B. (L)..........196 Irving Park Drive., Battle Creek 49017
Long, Walter B.........................Homer 49245
Lowe, Kenneth H.....231 North Ave., Battle Creek 49017
Lowe, Stanley T. (R)................12 Hiawatha Dr., Battle Creek 49015
Lund, C. A. E.....135 Hamblin Ave., Battle Creek 49014
Maurer, James J...............616 Mich. Natl. Bk. Bldg., Battle Creek 49014
McCuaig, Alfred G.................719 Capital St. SW, Battle Creek 49015
McGee, John W............105 Irwin Ave., Albion 49224
Melges, Fredk. J.................25 W. Michigan Ave., Battle Creek 49014
Moir, Hugh K. (A)..95 W. Spaulding, Battle Creek 49017
Morrison, Donald B...719 Capital S.W., Battle Creek 49015
Mullenmeister, H. F...275 Capital N.E., Battle Creek 49017
Murillo, Casmir....235 North Avenue, Battle Creek 49017
Netreba, Jules L........112 W. Mansion, Marshall 49068
Norgan, Anne F.................719 Capital Ave. S.W., Battle Creek 49015
Parkinson, Chas. E...1018 North Ave., Battle Creek 49015
Patrick, Gilbert T.................25 W. Michigan Ave., Battle Creek 49014
Patt, Albert J...........154 West St., Battle Creek 49017
Pearson, Donald J.....255 North Ave., Battle Creek 49017
Pier, Clarence T. (A)...80 Griffin Ct., Battle Creek 49015
Pipe, Lawrence D......Leila Hospital, Battle Creek 49014
Powell, C. E.........632 North Ave., Battle Creek 49017
Powell, Donna (A)......V. A. Hospital, Ft. Custer 49016
Power, John R..........154 West St., Battle Creek 49017
Robbert, John (L).......191 College, Battle Creek 49017
Roberge, Jerome T..............1001 Security Bk. Bldg., Battle Creek 49014
Rorich, Wilma C. W. (R) 86 Oaklawn, Battle Creek 49017
Rowan, Russell C..........500 S. Ionia St., Albion 49224
Royer, Clark W.................1331 W. Michigan Ave., Battle Creek 49017
Ryan, Chas. J............Leila Hosp., Battle Creek 49014
Seifert, Charles (M)..................6231 Peace Pipe, San Antonio, Tx. 78238
Sevidal, Pedro A., Jr.............512 Mich. Bank Bldg., Battle Creek 49014
Sharp, Ara D. (R).........502 Irwin Ave., Albion 49224
Shellenberger, H. M. (R).131 W. Hanover, Marshall 49068
Shipp, Leland P. 25 W. Michigan Ave., Battle Creek 49014
Sibilsky, A. Clark (A)................281 Honey Lane, Battle Creek 49015
Simpson, Robt. S................700 Capital Ave. S.W., Battle Creek 49015
Slagle, Geo. W. (L)............203 Capital Ave. N.E., Battle Creek 49017
Spencer, Collis M.....308½ S. Superior St., Albion 49224
Stadle, Wendall H. (R)..........607 Jennings Landing, Gougac Lake, Battle Creek 49014
Stephenson, C. D.......154 West St., Battle Creek 49017
Stiefel, Richard A.................25 W. Michigan Ave., Battle Creek 49014
Strohmenger, Frank J..........500 S. Ionia, Albion 49224
Taylor, Clifford B..........500 S. Ionia St., Albion 49224
Tazelaar, Myron A....219 N. Madison St., Marshall 49068
Thompson, Walter C. (A)........Battle Creek Hlt. Ctr., Battle Creek 49014
Vander Kamp, Harry (A) V.A. Hospital, Battle Creek 49016
Vander Voort, Wm. V. (L).........R. 4, Hastings 49058
Verity, Lloyd E. (R)..36 Parkside Dr., Battle Creek 49017
Vetne, Gunnar......725 Capital S.W., Battle Creek 49015
Walker, Chas. S..................709 W. Van Buren St., Battle Creek 49017
Walters, John F.......163 North Ave., Battle Creek 49017
Walters, Wm. D.......175 College St., Battle Creek 49017
Wemmer, Keith S..............1472 W. Michigan Ave., Battle Creek 49017
Winslow, Sherwood B. 710 North Ave., Battle Creek 49017
Worgess, Duane R................799 Capital Ave. N.E., Battle Creek 49017
Yannitelli, S. A........710 North Ave., Battle Creek 49017
Young, John R...719 Capital Ave. S.W., Battle Creek 49015
Zaplitny, R. B.......1018 North Ave., Battle Creek 49017
Zaplitny, Sophia (A) 1018 North Ave., Battle Creek 49017
Zheutlin, Bertram......50 Adams St., Battle Creek 49015
Zindler, Geo. A................1201 Security Bnk. Bldg., Battle Creek 49014

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M.......................Marcellus 49067
Clary, Rudolph I. (R) Indian Hills R#3, Dowagiac 49047
Comstock, L. David, Jr...417 W. High St., Dowagiac 49047
Devarona, Justo......420 W. High St., Dowagiac 49047
Guzzo, Henry V....515 Main St., Suite 1, Dowagiac 49047
Hickman, John K....108 W. Division St., Dowagiac 49047
Loupee, Sherman L. (L)...108 Orchard, Dowagiac 49047
Pierce, Kenneth C.......417 W. High St., Dowagiac 49047
Smith, Lowell D.........109 School St., Cassopolis 49031
Warren, Aaron K........109 School St., Cassopolis 49031

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R.....816 Ashmun St., Sault Ste. Marie 49783
Blair, H. Milton.....300 Court St., Sault Ste. Marie 49783
Clausen, Claire H. (L)..............1110 Lucerne Ave., Cape Coral, Fla. 33904
Coulter, Wm. J.................Drummond Island 49726
Finlayson, Donald D.................301 E. Spruce St., Sault Ste. Marie 49783
Hagele, Marie A......126 Park Pl., Sault Ste. Marie 49783
Hamel, Herbert E.....................St. Ignace 49781
Harrington, Harvey M. (L)..................Box 319, Sault Ste. Marie 49783
Heilman, Robert D................War Memorial Hosp., Sault Ste. Marie 49783
Howe, Donnell C., Jr. 300 Court St., Sault Ste. Marie 49783
Mackie, Thos. B......300 Court St., Sault Ste Marie 49783
McBryde, Lyman M....................416 Ashmun St., Sault Ste. Marie 49783
Mertaugh, Wm. F...................104 W. Spruce St., Sault Ste. Marie 49783
Montgomery, Benj. T. (L)................P. O. Box 39, Sault Ste. Marie 49783
Reddick, C. E...............Chippewa Co. Hlth. Dept., Sault Ste. Marie 49783
Rhind, Earl S.....Sault Polyclinic, Sault Ste. Marie 49783
Scott, Dale.......816 Ashmun St., Sault Ste. Marie 49783
Solomon, Joseph A...............Mackinac Island 49757
Thompson, Chas. F. (L)........Drummond Island 49726
Trapasso, Tony J.....816 Ashmun, Sault Ste. Marie 49783
Tygart, Robert L....301 E. Spruce, Sault Ste. Marie 49783
Venier, Anton G...816 Ashmun St., Sault Ste. Marie 49783
Wedding, Erling S.....................203 Hudson Dr., Sault Ste Marie 49783

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W...........203 W. Main St., Elsie 48831
Cook, Bruno C........................Westphalia 48894
Fillinger, Wells B. (L)....................Ovid 48866
Foo, Chas. T. (L)..1716 30th St. W., Bradenton, Fl. 33505
Grost, James M............Park Avenue, St. Johns 48879
Henthorn, Arthur C. (L).......Box 216, St. Johns 48879
Russell, Sherwood R...104 N. Oakland St., St. Johns 48879
Scott, James S..........................DeWitt 48820
Sheline, Victor L...........Medical Center, Ithaca 48847
Slagh, Earl M...........................Elsie 48831
Smith, Franklin W.......205 W. State St., St. Johns 48879
Stephenson, Wesley F...510 E. Walker St., St. Johns 48879
Stoller, Paul F........................St. Johns 48879

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C......218 S. 10th St., Escanaba 49829
Bash, Theodore L.....................Bark River 49807
Bernier, A. B. (R)....624 Ludington St., Escanaba 49829
Berry, Roland E.......St. Francis Hosp., Escanaba 49829
Cretens, Mary...........567 N. Ninth, Gladstone 49837
Dehlin, James R............8 S. 11th St., Gladstone 49837
Fitch, Donald N...........Doctor's Park, Escanaba 49829
Fyvie, James H.......202 S. Cedar St., Manistique 49854
Gordon, E. James.......117 N. 22nd St., Escanaba 49829
Groos, Louis P..........1015 S. 1st Ave., Escanaba 49829
Hockstad, Raymond.......Doctor's Park, Escanaba 49829
Hult, Otto S...........1005 Delta Ave., Gladstone 49837
LaSorsa, Armand M...................Manistique 49854
Le Mire, Donald F.....1104 S. First Ave., Escanaba 49829
Le Mire, John........1104 S. First Ave., Escanaba 49829
Le Mire, William A....1106 First Ave. S., Escanaba 49829
Maniaci, Geo...........8 South 11th St., Gladstone 49837
McInerney, Thos. A...1221 Ludington St., Escanaba 49829
Olson, Carl J.............8 S. 11th St., Gladstone 49837
Ryde, Robt. E...........1221 Ludington, Escanaba 49829
Sayani, Ian..........4792 Nakoma Drive, Okemos 48864
Theisen, Nikolaus J...1400 16th Avenue S., Escanaba 49829
Waters, Duane L.......200 S. Cedar St., Manistique 49854
Wehner, Merle E.........131 River St., Manistique 49854
Whipple, Arno.........Rural Station, Moorestown 49651

DICKINSON-IRON COUNTY MEDICAL SOICETY (54)

Addison, Earl R....412 Superior Ave., Crystal Falls 49920
Alexander, Wm. H. (L)................411 East C St., Iron Mountain 49801
Anderson, Donald T...408 Hamilton Ave., Kingsford 49801
Boyce, George H. (L)............First Natl. Bank Bldg., Iron Mountain 49801
Boyce, George H., Jr. (A)............700 Hamilton Ave., Kingsford 49801
Carlson, Ralph E................500 Stephenson Ave., Iron Mountain 49801
Cecconi, R. D..................Commercial Bank Bldg., Iron Mountain 49801
Cooper, Chas. A..............Box 542, Stambaugh 49964
Gendzwell, Joyce..805 Vulcan Street, Iron Mountain 49801
Gladstone, Wm. R., Jr.......804 Main St., Norway 49870
Hayes, Willard N.........720 N. Main St., Norway 49870
Huron, Willis H.....106 West B St., Iron Mountain 49801
Irvine, Lionel E. (L)..........Box 438, Iron River 49935
Jacobs, Donald J...Professional Bldg., Iron Mountain 49801
Kofmehl, Wm. J. (L).................Stambaugh 49964
McEachran, Hugh D..............500 Stephenson Ave., Iron Mountain 49801
Newkirk, John A......Khoury Bldg., Iron Mountain 49801
Nora, James C..........15 Eighth Ave., Iron River 49935
Pieper, Ernest....1517 S. Stevenson, Iron Mountain 49801
Retallack, Russell C...326 W. Genesee St., Iron River 49935
Roberts, Warren J. (A)............1020 Carpenter Ave., Iron Mountain 49801
Schmutzler, Walter A................373 Woodward St., Iron Mountain 49801
Schroeder, John M.....Khoury Bldg., Iron Mountain 49801
Sherk, Douglas..........412 Superior, Crystal Falls 49920
Smith, Donald R...........Box 471, Iron Mountain 49801
Steinke, Chas. G....................517 Stephenson Ave., Iron Mountain 49801
Trump, Paul L.................Commercial Bank Bldg., Iron Mountain 49801
Wollum, Arnold (A)................R. 1, Vulcan 49892

EATON COUNTY MEDICAL SOCIETY (58)

Berg, Richard H...........162 Second St., Sunfield 48890
Brown, Byron P...541 Lansing St., Apt. 2, Charlotte 48813
Butler, Vernon C. (A)
Carothers, Danl. J........125 Lansing St., Charlotte 48813
Curtis, Keith L..........202 S. Cochran, Charlotte 48813
De Land, C. Le Roy.......................Olivet 49076
Engle, Paul H. (A).......................Olivet 49076
Erhard, O. Stewart......301 Rancho, Eaton Rapids 48827
Garlock, Fred C...406 E. Jefferson St., Grand Ledge 48837
Harrod, Gordon R...................Grand Ledge 48837
Joseph, Daniel D........202 S. Cochran, Charlotte 48813
Meinke, Albert H., Jr..............800 Cumberland Dr., Eaton Rapids 48827
Myers, Albert W......................Potterville 48876
Passos, Benjamin A...304 N. Cochran Ave., Charlotte 48813
Robinson, S. R.......1140 Willow St., Grand Ledge 48837
Sevener, Lester G........236 S. Main St., Charlotte 48813
Sherman, Eber B.....501 Carlisle St., Eaton Rapids 48827
Van Ark, Bert.............511 Hale, Eaton Rapids 48827
Van Ark, Herman F.....410 Blake St., Eaton Rapids 48827
Willits, Clayton O..........127 Upland, Charlotte 48813

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick....420 S. Ballenger Hwy., Flint 48504
Adams, Albert C.............5210 Lapeer Rd., Flint 48503
Adams, Burnell H..........609 S. Lynch St., Flint 48503
Alexander, Leroi J.....5003 N. Saginaw St., Flint 48505
Anderson, Harley H...11820 N. Saginaw, Mt. Morris 48458
Anderson, John L.........2765 Flushing Rd., Flint 48504
Antell, Richard A........2733 Crestwood Dr., Flint 48503
Anthony, Geo. E. R...........912 Beard St., Flint 48503
Baird, W. Claire..........2765 Flushing Rd., Flint 48504
Bald, Fredk. W............410 S. Ballenger, Flint 48504
Barbour, David A.............5369 Briarcrest, Flint 48504
Barbour, Fleming A........2015 Lincoln Dr., Flint 48503
Baske, Franklin W...........923 Maxine St., Flint 48503
Batdorf, Joseph T...11325 S. Saginaw, Grand Blanc 48439
Bateman, Lawrence G.........1928 Lewis St., Flint 48506
Beck, Douglass R........5445 Fernwood Dr., Flint 48504
Becker, Eugene B.........2849 Miller Road, Flint 48503
Benkert, Jack...6211 Lake Forest Dr., Grand Blanc 48439
Benson, John C.........639 Mott Fdtn. Bldg., Flint 48502
Berman, Harry.............3309 Fenton Rd., Flint 48507
Berner, Gerald P..........2765 Flushing Rd., Flint 48504
Bernstein, Eli N............311 E. Court St., Flint 48503
Berry, Robert E. L.....715 Mott Fdtn. Bldg., Flint 48502
Best, J. A...................3803 Clio Rd., Flint 48504
Beyer, Geo. D.............G 3337 W. Vienna, Clio 48420
Bogart, Leon M. (L).....503 National Bldg., Flint 48502
Bolduc, Gregoire............325 E. First St., Flint 48502
Boles, Wm. P. (L)...........714 Beach St., Flint 48502
Bonet, Virgilio...........2765 Flushing Rd., Flint 48504
Bosker, Donald....1818 Longway Blvd. #302, Flint 48506
Bota, Robert A..............1623 Montclair, Flint 48503
Boyer, Peter R........100 Medical Arts Bldg., Flint 48501
Bradley, Robt. M.......1112 Mott Fnd. Bldg., Flint 48502
Brady, John L.........710 Mott Fdtn. Bldg., Flint 48502
Brain, Roy G. (L)........460 S. Saginaw St., Flint 48502
Branch, Hira E.........821 Mott Fdtn. Bldg., Flint 48502
Brasie, Donald R. (R)...R. 2, Box 436, Roscommon 48653
Briggs, Guy D. (L).........224 E. Court St., Flint 48503
Brown, Clarence A.....926 Mott Fdtn. Bldg., Flint 48502
Bryant, Donald R.......621 Mott Fdtn. Bldg., Flint 48502
Buchanan, Gerald S.......211 S. Saginaw St., Holly 48442
Buchanan, Wm. F.........238 W. Caroline, Fenton 48430
Burkett, Leslie V.........618 Dougherty Pl., Flint 48504
Canada, Donald R....1207 N. Ballenger Hwy., Flint 48504
Canas, Robert R.......406 N. Saginaw St., Durand 48429
Carter, Norman A.......739 Mott Fdtn. Bldg., Flint 48502
Chambers, Myrton S. (L)........3402 Westwood Pkwy., Flint 48503
Chardoul, Eugene N.......202 Paterson Bldg., Flint 48502
Chase, Wm. D.......1318 N. Ballenger Hwy., Flint 48504
Chogich, John C.............1245 Dupont St., Flint 48504
Clark, Robt. L............1301 Flushing Rd., Flint 48504
Cole, Gerald G.........1818 Longway Blvd., Flint 48501
Collie, Ross J...............1812 E. 2nd St., Flint 48503
Collins, James I.........G 1128 N. Dye Road, Flint 48504
Colwell, Clifford W.......328 S. Saginaw St., Flint 48502
Congdon, David E.......9190 Pine Bluff, Flushing 48433
Conover, Geo. V.....207 Genesee Bank Bldg., Flint 48502
Conover, McClellan B...625 S. Grand Traverse, Flint 48503
Cook, Frank W............410 S. Ballenger, Flint 48504
Cook, Henry (L)....208 Genesee Bank Bldg., Flint 48502
Cookingham, Cory E...208 Medical Arts Bldg., Flint 48501
Coriasso, Louis B...............9224 Happy Hollow Ct., Grand Blanc 48439
Coyne, Kenneth M...........325 E. First St., Flint 48503
Cross, Robert L.........5221 Woodhaven Dr., Flint 48504
Cutler, G. Campbell........420 S. Ballenger, Flint 48504
Damm, John R........8483 Holly Rd., Grand Blanc 48439
Davis, Robt. C..........G 3029 Flushing Rd., Flint 48504
Dawson, Ralph E.........721 W. Sixth Ave., Flint 48503
Day, John Murray..........315 E. Court St., Flint 48503
Delzingro, Nicholas (L).....328 Main St., Davison 48423
Dettman, Carlton K...12023 N. Seymour, Montrose 48457
Dickstein, Bernard........605 National Bldg., Flint 48502
Diggs, Roy D., Jr.......4250 N. Saginaw St., Flint 48505
Dismond, Samuel R......1402 S. Saginaw St., Flint 48503
Dodds, Fredk. E. (L)........1336 Lewis St., Flint 48506
Dodds, Max E........625 S. Grand Traverse, Flint 48503
Dooley, James F.........3210 S. Dort Hwy., Flint 48507
Dwyer, William F.....625 S. Grand Traverse, Flint 48503
Dykewicz, Richard A......2744 Flushing Rd., Flint 48504
Eaton, Wayne L........926 Mott Fdtn. Bldg., Flint 48502
Eichhorn, Ernest M.......2765 Flushing Rd., Flint 48504
Eickhorst, Thos. N........2765 Flushing Rd., Flint 48504
Ekinci, Mehmet 2279 Grand Blanc Rd., Grand Blanc 48439
Elliott, Hardie B..........503 S. Saginaw St., Flint 48502
Engelman, Raymond M........2744 Flushing, Flint 48504
Esfahani, Ali A.......710 Mott. Fdtn. Bldg., Flint 48502
Ettinger, Ralph D.....238 W. Caroline St., Fenton 48430
Failing, John F., Jr.........Hurley Hospital, Flint 48502
Fan, Q. C................2002 E. Court St., Flint 48503
Farah, Ben S.............2765 Flushing Rd., Flint 48504
Farhat, Maynard M.........505 W. Court St., Flint 48503
Fee, Manson G...........108 E. Kearsley St., Flint 48502
Fernandez, Jose A.........2765 Flushing Rd., Flint 48504
Ferris, James W..............1005 Leith St., Flint 48505
Finkelstein, Theo.......1415 Broadway Blvd., Flint 48506
Fitch, Robert E..................1005 Leith, Flint 48505
Forrer, Graydon R.............2279 E. Grand Blanc Rd., Grand Blanc 48439
Friedman, Leon..........2765 Flushing Rd., Flint 48504
Fuller, Harvey T. (R)................2700 N. Hayden, Scottsdale, Az. 85257
Gerras, George Z.........1909 Lynbrook Dr., Flint 48507
Gibbons, James J.....101 Medical Arts Bldg., Flint 48501
Goetz, Rudolph..........1221 Church Street, Flint 48503
Goldberg, E. Marshall.......Hurley Hospital, Flint 48502
Golden, Evelyn.............218 E. Court St., Flint 48503
Golden, H. Maxwell.........218 E. Court St., Flint 48503
Gorne, Saul S...............619 Clifford St., Flint 48503
Griffin, Ernest P., Jr........1505 Arrow Lane, Flint 48507
Grommons, Jack R.........721 W. Sixth Ave., Flint 48503
Grover, Harold F. (L)......3433 Fenton Rd., Flint 48507
Guile, Gurdon S. (A).....1621 Dupont St., Flint 48504
Gullekson, Edwin H.......2765 Flushing Rd., Flint 48504
Gumpper, C. R.....4437 Morrish Rd., Swartz Creek 48473
Gundry, Geo. L. (L)..11736 Saginaw, Grand Blanc 48439
Gutow, Isadore H.........2765 Flushing Rd., Flint 48504
Gutow, Julius J..........726 Church Street, Flint 48503
Gutow, Richard F. (A) P. O. Box 6085, Denver, Co. 80240
Gutowitz, Erwin......420 S. Ballenger Hwy., Flint 48504
Hackley, Richard D...........1818 R. T. Longway Blvd., Flint 48501
Hague, Robt. F. (L)......8231 River Rd., Flushing 48433
Hallitt, John Wm.....102 Medical Arts Bldg., Flint 48501
Harper, Robt. H.............713 Thomson St., Flint 48503
Harris, Bernard J.............1750 Lynbrook, Flint 84507
Harris, Donald R..........2429 Welch Blvd., Flint 48504

Hauser, Fredk. V......1015 Mott Fdtn. Bldg., Flint 48502
Hawkins, James E..........4618 Roberts St., Flint 48501
Heinemann, Herman J.....G7316 Calkins Rd., Flint 48504
Helcher, Phyllis O.....G5303 Flushing Rd., Flushing 48433
Helferty, Robert D.....1116 Ann Arbor Street, Flint 48503
Helmer, Fredric A. (A)................275 Kings Point, Great Neck, L.I., N.Y. 11024
Hennessy, Charles R.....517 Mott Fdtn. Bldg., Flint 48502
Hiscock, Harold H. (L)..........1315 Mott Fdtn. Bldg., Flint 48502
Hockman, Thomas A.............11125 Old Bridge Rd., Grand Blanc 48439
Hodges, Frank V............Hurley Hospital, Flint 48502
Hollis, John W.............4300 S. Saginaw, Flint 48507
Hooper, Virgil R.............4230 Trumbull, Flint 48504
House, Robert J........5481 Sugarbush Lane, Flint 48504
Hubbard, Wm. C. .....302 Paterson Building, Flint 48502
Hufton, Wilfrid L.........2765 Flushing Rd., Flint 48504
Hunt, Richard J. 6259 Lake Forest Dr., Grand Blanc 48439
Hurd, Clayton E...........205 Lincoln St., Fenton 48430
Irish, Lawrence R...........6146 Sierra Pass, Flint 48504
James, Robt. E.............1860 Hampden, Flint 48507
Janke, Walter H........603 Mott Fdtn. Bldg., Flint 48502
Johnson, A. H., Jr...........429 North St., S.W., #506, Washington, D.C. 20024
Johnson, Frank D.................12606 Via Catherine, Grand Blanc 48439
Johnson, Raymond E.................5173 W. Reid Rd., Swartz Creek 48473
Judd, Alvin E.............1620 N. Franklin, Flint 48506
Karr, Paul H...............3416 Lapeer Rd., Flint 48503
Kaufman, Lewis D.......4002 N. Saginaw St., Flint 48505
Kelly, James E............2765 Flushing Rd., Flint 48504
Kennett, Donald M.................315 Bella Vista Dr., Grand Blanc 48439
Kimbrough, C. B.........1402 S. Saginaw St., Flint 48503
Kitto, Harold J...............902 Stockdale, Flint 48504
Kline, O. F...............2765 Flushing Rd., Flint 48504
Knapp, Wm. D...........503 S. Saginaw St., Flint 48502
Knoblich, Roman R..........Hurley Hospital, Flint 48502
Koop, Chester S.....1372 N. Ballenger Hwy., Flint 48504
Kreel, Boris W.......11610 Hazel St., Grand Blanc 48439
Kretchmar, Arthur H. (L)..........481 St. Andrews Dr., Aptos, Calif. 95003
Laird, James I..........12010 Kipp Rd., Goodrich 48438
Laurel, Richard J..........1207 N. Ballenger, Flint 48504
La Vielle, Carroll J.........1135 N. Dye Rd., Flint 48504
Leach, J. Leonidas (L)..5014 N. Saginaw St., Flint 48505
Le Mieux, Leslie L........701 W. Dayton St., Flint 48504
Levine, Mark C.........G3083 Flushing Rd., Flint 48504
Lewis, Billie...........739 Mott Fdn. Bldg., Flint 48502
Lewis, Thos. E............4071 Richfield Rd., Flint 48506
Lewis, Vivian M............1618 Kensington, Flint 48503
Lieber, Robt. W.......6144 Pebbleshire Circ., Flint 48507
Lightfoot, Arthur S..........4500 Detroit St., Flint 48505
Limbach, David R............900 Begole St., Flint 48503
Lindman, Thomas C..........2484 Nolen Dr., Flint 48504
Livesay, Jackson E. (L)...503 S. Saginaw St., Flint 48502
Lundeen, Richard M..............3393 Clio, Flint 48504
Lusk, John A........9233 W. Davison Rd., Davison 48423
Lyttle, Sydney N.....1207 N. Ballenger Hwy., Flint 48504
MacKenzie, J. W., Jr..................4437 Morrish Rd., Swartz Creek 48473
Macksood, Albert J.......3169 W. Pierson Rd., Flint 48504
Macksood, John M......3169 W. Pierson Rd., Flint 48504
Macksood, Jos. A..........3169 W. Pierson Rd., Flint 48504
Macksood, William E.....3169 W. Pierson Rd., Flint 48504
MacPhail, Albert A.......3302 Hawthorne Dr., Flint 48503
Mangelsdorf, C. H...........G3393 Clio Rd., Flint 48504
Manwaring, John T.......G5432 Calkins Rd., Flint 48504
Markunas, Paul J........4002 N. Saginaw St., Flint 48505
Martin, James A........812 S. Adelaide St., Fenton 48430
Martins, Helio B. F............714 Beach St., Flint 48502
Mathias, Berton J..........1301 Flushing Rd., Flint 48504
McAlindon, J. D.................1601 Euclid, Flint 48503
McClellan, Junius W....Buick Motor Division, Flint 48505
McGrae, John D., Jr.......2433 Welch Blvd., Flint 48504
McGregor, Allan R.....G 3337 W. Vienna Rd., Clio 48420
McLeod, Kenneth W. A....2765 Flushing Rd., Flint 48504
McMurray, Richard J......2765 Flushing Rd., Flint 48504
McNaughton, D. W...2437 Pinewood Ct., Flushing 48433
McTaggart, David.....625 S. Grand Traverse, Flint 48503
Mendrek, H. H...........2765 Flushing Rd., Flint 48504
Michael, Sidney R.........922 Welch Blvd., Flint 48504
Michels, Robt. M.........2702 Flushing Rd., Flint 48504
Michelson, Richard B...........2014 Robt. T. Longway, Flint 48503
Mikat, Kurt W..........3402 Santa Clara Ct., Flint 48504
Miller, Loren E...........2645 Corunna Rd., Flint 48503
Miltich, Anthony J.....915 S. Grand Traverse, Flint 48503
Moeller, Jan C..........3102 Westwood Pky, Flint 48503
Moore, Glenn E.............323 W. Second, Flint 48503
Morgan, Alan L.........3169 W. Pierson Rd., Flint 48504
Morin, Paul................1968 Miller Rd., Flint 48503
Morrissey, Vaughn H.......101 Stockdale St., Flint 48503
Mosier, Edward C.........1730 Overhill Dr., Flint 48503
Mueller, Willys F.......13335 Pamona Dr., Fenton 48430
Murphy, E. Grant......926 Mott Fdtn. Bldg., Flint 48502
Nassar, S. H..........8483 Holly Rd., Grand Blanc 48439
Newman, Harry S...........302 E. Court St., Flint 48503
Newton, Barnabas (A).....McLaren Hospital, Flint 48502
Nicholls, Wm. W..........806 W. Sixth Ave., Flint 48503
Nitz, Donald A.....1818 Robert T. Longway, Flint 48503
Odle, Ira D. (L)...........201 Welch Blvd., Flint 48503
Oldt, Mary Ruth...........602 S. Lynch St., Flint 48503
Orr, John W. (L).....Orrs Pt., Lk. Fenton, Fenton 48430
Osher, Seymour L.........315 E. Court St., Flint 48503
Pappalardo, Carlos................11314 Comway Rd., Ladue, Missouri 63131
Park, Joon H..........500 S. Grand Traverse, Flint 48503
Parliament, Burt A.........314 Ferndale Pl., Flint 48503
Pfeifer, Archibald C. (L).......9798 Palmetto Club Dr., Miami, Fl. 33157
Phelps, Lynn A........10122 Janaroy Ct., Goodrich 48438
Phillips, A. F......X-ray Dept., Hurley Hosp., Flint 48502
Pickering, Woodrow H...1602 Ballenger Hwy., Flint 48504
Pietruszka, B..............5210 Lapeer Rd., Flint 48503
Pike, Wallace W....7514 Miller Rd., Swartz Creek 48473
Platt, Alice Lee (A)...............5551 Territorial Rd., Grand Blanc 48439
Portney, Jack E..............725 Stevens St., Flint 48503
Pougnet, W. D............6155 Maple Ridge, Flint 48504
Pratz, Oliver C. (L)........1303 Detroit St., Flint 48503
Preston, Otto J.........300 N. Chevrolet Ave., Flint 48504
Price, Jack R..........410 S. Ballenger Hwy., Flint 48504
Prior, Richard W..........1266 S. Le Roy, Fenton 48430
Purcell, F. L................Ternstedt Plant, Flint 48509
Quin, John, Jr.............2765 Flushing Rd., Flint 48504
Quinn, Jarlath.............1116 Ann Arbor, Flint 48503
Rabiah, Fouad........1139 Mott Fdn. Bldg., Flint 48502
Radcenko, Helen........302 W. Pierson Rd., Flint 48505
Radcenko, Leonid........302 W. Pierson Rd., Flint 48505
Rao, D. S...........1207 N. Ballenger Hwy., Flint 48504
Rapport, Richard L.........436 S. Saginaw, Flint 48502
Rathburn, Robert J........1501 Flushing Rd., Flint 48504
Rawling, John C........115 Med. Arts. Bldg., Flint 48504
Rawlings, J. Mott..........1601 Neome Dr., Flint 48503
Reid, John H.............1301 Flushing Rd., Flint 48504
Reye, George H..............2279 E. Grand Blanc Rd., Grand Blanc 48439
Rice, Alan K.........2008 Robt. T. Longway, Flint 48503
Rieth, Geo. F..............1406 Davison St., Flint 48506
Roberts, Floyd A. (L)..327 Sheffield, Apt. 281, Flint 48503
Robitaille, M. L...........2765 Flushing Rd., Flint 48504
Rowe, John B...............653 Saginaw St., Flint 48502
Rundles, Walter Z.....500 Grand Traverse St., Flint 48503
Sampaio, Carlos A........8020 Davison Rd., Davison 48423
Sandberg, Russell G......5431 Fernwood Dr., Flint 48504
Sanocki, Fredk. E......915 S. Grand Traverse, Flint 48503
Scavarda, Chas. J..............1106 Maxine, Flint 48503
Schaefer, Richard K.......3248 Van Slyke Rd., Flint 48507
Schafer, Nelson S..........721 W. 6th Ave., Flint 48503
Schiff, Benton A.............323 W. 2nd St., Flint 48503
Schmidlin, Robt. W.........3710 Davison Rd., Flint 48506
Schreiber, E. Oskar......2765 Flushing Road, Flint 48504
Schroeder, Paul E.........1673 N. Chevrolet, Flint 48504
Schultz, J. Stanley.........3327 Fleming Rd., Flint 48504
Schwartz, John M........1300 N. Dort Hwy., Flint 48506
Schwarz, Heinz H.................5551 Territorial Rd., Grand Blanc 48439
Seven, Phillip G............2301 Cummings, Flint 48503
Seymour, Geo. D.....G7237 N. Saginaw, Mt. Morris 48458

Shantz, Leighton O. 1497 Country View Lane, Flint 48504
Sheehy, James P.........503 S. Saginaw St., Flint 48502
Sheeran, Danl. H.........610 S. Vernon Ave., Flint 48503
Sherwood, Frederick.......2765 Flushing Rd., Flint 48504
Shields, John L........234 W. Caroline St., Fenton 48430
Simoni, Lewis E.........3210 S. Dort Hgwy., Flint 48507
Singh, Sarjit........839 Mott Fndtn. Bldg., Flint 48502
Sirna, Anthony R....11219 Stonybrook, Grand Blanc 48439
Smalley, R. H.....4437 Morrish Rd., Swartz Creek 48473
Smith, Eugene C...............606 Stevens, Flint 48503
Smith, Harold O............3769 Sunset Dr., Flint 48503
Smith, Maurice J........2801 N. Saginaw St., Flint 48505
Smith, Sidney E.......625 S. Grand Traverse, Flint 48503
Sniderman, Benj. F............727 Beach St., Flint 48502
Solik, A. E................311 E. Court St., Flint 48503
Somach, Fredric M........2765 Flushing Rd., Flint 48504
Sorkin, Morris L..............718 Beach St., Flint 48502
Sorkin, Saml. S...............718 Beach St., Flint 48502
Sorscher, Alan J.......420 S. Ballenger Hwy., Flint 48504
Southall, Warren E.........4250 N. Saginaw, Flint 48505
Sparks, Harvey V.........2765 Flushing Rd., Flint 48504
Steffe, Ralph S...........2765 Flushing Rd., Flint 48504
Steinman, Floyd H.......503 S. Saginaw St., Flint 48502
Stevens, Philip K......1116 Mott Fdtn. Bldg., Flint 48502
Stevenson, Wm. W. (L)....1521 Arrow Lane, Flint 48507
Streat, Rudolph W. (L).8100 Davison Rd., Davison 48423
Stroup, Clayton K.........2002 E. Court St., Flint 48503
Sullivan, M. R....5352 Peppermill Rd., Grand Blanc 48439
Sutherland, James K. (L).....402 E. 3rd St., Flint 48503
Sutton, Geo. D. (L).......303 W. Court St., Flint 48503
Tang, Gene D. (A)..Irwin Hosp., Ft. Riley, Kansas 66442
Tauscher, John W...2016 R. T. Longway Blvd., Flint 48503
Theuerle, Walter I.......3101 N. Saginaw St., Flint 48505
Thompson, Charles A......4211 Comstock St., Flint 48504
Thompson, Jack W........2702 Flushing Rd., Flint 48504
Thoms, Peter S.......1279 W. Coldwater Rd., Flint 48505
Tofteland, Elmer H.......2765 Flushing Rd., Flint 48504
Tower, Rita B. (L).............Elms Trailer Park, D4, 2801 S. Dort Hwy., Flint 48507
Turcke, Allen F............1245 Dupont St., Flint 48504
Turner, Merald G.........G 3169 W. Pierson, Flint 48504
Tuuri, Arthur L.........Mott Children Clinic, Flint 48502
Urich, Vernon..........3169 W. Pierson Rd., Flint 48504
VanBrocklin, J. D.........2765 Flushing Rd., Flint 48504
Van Duyne, Fredk. W.......2849 Miller Rd., Flint 48503
Van Harn, Raymond S.....1116 Ann Arbor St., Flint 48503
Varjavandi, Siavosh.....3169 W. Pierson Rd., Flint 48504
Varney, Howard L. 1818 Robt. Longway Blvd., Flint 48503
Varol, Adnan O.........432 N. Saginaw St., Flint 48502
Vaughan, Edgar J.........319 S. Bridge St., Linden 48451
Velarde, Nicholas N.......3083 Flushing Rd., Flint 48504
Villarreal, Virgilio............3917 Kellar St., Flint 48504
Wade, Franklin V...436 S. Saginaw St., #410, Flint 48502
Walcott, Carver G......201 E. Carolina St., Fenton 48430
Walker, James D.
Walter, Daniel L.........820 Davison Rd., Davison 48423
Ward, Nell M. (L).....G4152 Carnation Ct., Flint 48506
Weber, Richard E.....420 S. Ballenger Hwy., Flint 48504
Weber, Robt. M...........3710 Davison Rd., Flint 48506
Wentworth, John E..........420 S. Ballenger, Flint 48504
Werness, Inga W. (L)...220 East Fourth St., Flint 48503
West, George A.........4250 N. Saginaw St., Flint 48505
Wheeler, J. D..........926 Mott Fdtn. Bldg., Flint 48502
White, Carl H..............106 River St., Fenton 48430
White, Frank T............5210 Lapeer Rd., Flint 48503
Whites, Jack C.........7343 Flushing Rd., Flushing 48433
Willard, Robt. H..............718 Beach St., Flint 48502
Williams, Wm. S. (L) 5216 S. Genesee, Grand Blanc 48439
Willis, Robert E...........6606 N. Saginaw St., Flint 48505
Wills, Thos. N. (R)..Chicaugoan Lake, Crystal Falls 49920
Wolcott, Nan D. (R)....7506 Lapeer Rd., Davison 48423
Wolf, Melvyn D........G 3083 Flushing Rd., Flint 48503
Woodsides, K. T. (A)..6377 Flushing Rd., Flushing 48433
Wright, Geo. W., Jr. 2279 Grand Blanc, Grand Blanc 48439
Zeis, Myron G................718 Beach St., Flint 48502
Zelko, Daniel M...........4071 Richfield Rd., Flint 48506

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, Saml. G..........103 Suffolk St., Ironwood 49938
Davidson, Donald L.....200 S. Sophie St., Bessemer 49911
Franck, John R., Jr.....401 Sunday Lake, Wakefield 49968
Gallo, Bela.............Newport Clinic, Ironwood 49938
Gertz, Michael A......109 E. Aurora St., Ironwood 49938
Gorrilla, Allen C..........210 Suffolk St., Ironwood 49938
Harrington, Rex R., Jr...104 E. Ridge St., Ironwood 49938
Lieberthal, M. J. (L)..220 S. Suffolk St., Ironwood 49938
Lieberthal, Paul R. (L)..........Box 632, Ironwood 49938
Medford, Lester....306 Sunday Lake St., Wakefield 49968
Santini, Florian J.......109 E. Aurora St., Ironwood 49938

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Barstow, Richard G. (A)................3630 Garfield, Traverse City 49684
Bartone, John R.....217 S. Madison, Traverse City 49684
Beall, John G......1105 E. Front St., Traverse City 49684
Berens, Burdette M.....................Kalkaska 49646
Blount, Harry M...........116 Cass, Traverse City 49684
Bolan, Ellis S. I...............Box 67, Suttons Bay 49682
Brownson, Kneale M.....116 Cass St., Traverse City 49684
Bushong, Benj. B.......116 Cass St., Traverse City 49684
Campbell, Thomas D..................1634 S. High St., Traverse City 49684
Cartwright, Wm. H. 1105 E. Front St., Traverse City 49684
Clark, Oswald V.......1030 Sixth St., Traverse City 49684
Cline, Theodore N...........999 6th, Traverse City 49684
Cline, Warren W............999 6th, Traverse City 49684
Coleman, John F......1100 Sixth St., Traverse City 49684
Dundon, Arthur F.....1100 Sixth St., Traverse City 49684
Edmonds, W. T.......Munson Hosp., Traverse City 49684
Ellis, Claude I.......................Suttons Bay 49682
Fiebing, Jack A........P.O. Box 283, Traverse City 49684
Fishbeck, Wm. A.....1209 E. 8th St., Traverse City 49684
Fulmer, Roger C...9838 Peninsula Dr., Traverse City 49684
Haberlein, Chas. R.....1100 Sixth St., Traverse City 49684
Hall, James W.........1100 Sixth St., Traverse City 49684
Hall, Thomas C.......1100 Sixth St., Traverse City 49684
Hamilton, Earl E....530 S. Union St., Traverse City 49684
Harwood, Jerold R....1100 Sixth St., Traverse City 49684
Herkner, Mildred L. (A)........Traverse City St. Hosp., Traverse City 49684
Hubbell, Reader J. (L)...Rte 2, 323B, Suttons Bay 49682
Huene, Nevin......110 E. Front St., Traverse City 49684
Huston, R. R. (L)......................Elk Rapids 49629
Johnson, Robert C......116 Cass St., Traverse City 49684
Johnston, James D.....1100 Sixth St., Traverse City 49684
Kamp, Robt. L...........................Beulah 49617
Kaufman, James N........427½ Main St., Frankfort 49635
Kitti, Wm. W..........................Kalkaska 49646
Kolberg, James A.......211 S. High St., Northport 49670
Komesu, Seiichi.............Box C, Traverse City 49684
Larson, Conrad E...............Munson Medical Center, Traverse City 49684
Lemen, Charles E.....110 S. Madison, Traverse City 49684
Lieding, Keith G...7844 Peninsula Dr., Traverse City 49684
Lossman, Robt. T..............J. Decker Munson Hosp., Traverse City 49684
McClay, Adam C.......6330 Pen Dr., Traverse City 49684
Michael, Stanley L.....335 Davis St., Traverse City 49684
Milliken, John G......224 Circle Dr., Traverse City 49684
Novack, Richard L.........408 Main St., Frankfort 49635
Pearson, Robt. E. (A)..............611 Birchwood Ave., Traverse City 49684
Pelto, Maurice S....Munson Hospital, Traverse City 49684
Peterson, Wm. D....876 E. Front St., Traverse City 49684
Pike, Donald G.....1105 E. Front St., Traverse City 49684
Ponczek, E. J...Box C, State Hospital, Traverse City 49684
Power, Frank H.........116 Cass St., Traverse City 49684
Salon, Dayton D........1030 6th St., Traverse City 49684

Scheidler, Edw. P., Jr...............10610 Peninsula Dr., Traverse City 49684
Schroeder, Dwight M..................Northport 49670
Skendzel, L. P.....Munson Hospital, Traverse City 49684
Sladek, Edward F. (L)................123 E. Front St., Traverse City 49684
Sommerness, M. Duane.......Box C, Traverse City 49684
Sorum, F. T.................Box C, Traverse City 49684
Spencer, John R....1124 E. Front St., Traverse City 49684
Steffey, Jos. C.......116 Cass Street, Traverse City 49684
Stokes, G. Edward....1100 Sixth St., Traverse City 49684
Swartz, Fred G. (L)....612 Sixth St., Traverse City 49684
Sweeney, Bernard J....1100 Sixth St., Traverse City 49684
Thacker, Fredk. R.............Front St., Frankfort 49635
Thill, Leonard J.............Box C, Traverse City 49684
Thirlby, Richard L...228 S. Madison, Traverse City 49684
Toth, Joseph L.....318 Hamilton St., Traverse City 49684
Wagener, Creighton A. 1100 Sixth St., Traverse City 49684
Weih, Jack E......1105 E. Front St., Traverse City 49684
Weitz, Harry L.......Munson Hosp., Traverse City 49684
Wilcox, Paul H........333 Sixth St., Traverse City 49684
Wiley, Philip K.........116 Cass St., Traverse City 49684
Williams, Chas. R.......416 Sixth St., Traverse City 49684
Willoughby, Gordon W......104 5th St., Frankfort 49635
Wonacott, Robert G.....107 Dexter St., Elk Rapids 49629
Wright, J. K., Jr....1105 E. Front St., Traverse City 49684
Wunsch, Richard E...................1122 E. Front St., Traverse City 49684
Young, John Harley..Children's Clinic, Traverse City 49684
Zielke, Irwin H......106 S. Madison, Traverse City 49684
Zimmerman, Jos. G..606 N. Elmwood, Traverse City 49684

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L.........................Ithaca 48847
Bauer, A. Robert, Jr...412 E. Broadway, Mt. Pleasant 48858
Bayazit, Lutfi Y................Mt. Pleasant State Home, Mt. Pleasant 48858
Baybura, Orhan..........503 E. Main St., Edmore 48829
Becker, Myron G.......................Edmore 48829
Bedo, Andrew V.......802 Gordon, Mount Pleasant 48858
Bergin, Jos. H..............112 E. Superior, Alma 48801
Blaisdell, Glenn D...1222 North Dr., Mt. Pleasant 48858
Brenner, E. J. (R)..........Central Mich. Comm. Hosp., Mt. Pleasant 48858
Burt, Loren G..............510 Prospect St., Alma 48801
Chamberlain, Ray W..................608 E. Chippewa, Mount Pleasant 48858
Chamichian, Souren L......Canal Rd., Mt. Pleasant 48858
Davis, Lionel L...314 S. Brown St., Mount Pleasant 48858
Dunlop, Donald........301 East Fourth St., Clare 48617
Fishbaugh, Wm. F., Jr.......936 W. Center, Alma 48801
Graham, Bernard J........510 Prospect Ave., Alma 48801
Haddad, T. E.........712 Michigan Ave., St. Louis 48880
Hammerberg, Kuno...........622 McEwan, Clare 48617
Harrigan, Wm. L. (R)......90th at School Section Lk., Mecosta 49332
Hedges, Frank W.......215 W. Saginaw, St. Louis 48880
Henderson, B. G. (O)..320 W. Superior St., Alma 48801
Henderson, Wm. (O)..320 W. Superior St., Alma 48801
Hersee, Wm. E.....306 S. College, Mount Pleasant 48858
Hobbs, A. Deane (R)..Box 3233, Florence Vill., A Station, Winter Haven, Fl. 33880
Johnson, Frank D. (A) 806 E. Bellows, Mt. Pleasant 48858
Johnson, Philip R..................206 S. College Ave., Mount Pleasant 48858
Johnson, Robert B....................R. 1, Ithaca 48847
Juhnke, Le Roy W....................314 S. Brown St., Mount Pleasant 48858
Klauer, James D..Community Hospital, Mt. Pleasant 48858
Kumar, B. B.................Mt. Pleasant State Home, Mt. Pleasant 48858
Linn, Michael R.........Medical Arts Bldg., Alma 48801
Lusis, Alexsandrs (R)............St. Home & Tr. School, Mt. Pleasant 48858
McArthur, Stewart C.............Box 32, Rosebush 48878
Meyer, Edwin G..........................Alma 48801
Minster, John J......314 S. Brown St., Mt. Pleasant 48858
Nagler, Donald F............Route 3, Mt. Pleasant 48858
Nosan, Martin M................1105 Kent Dr., Rt. #3, Mt. Pleasant 48858
Philippon, Carlos A.....303 W. Superior St., Alma 48801
Ragan, Russell M...505 Hiawatha Dr., Mt. Pleasant 48858
Rank, Robert K................Central Comm. Hospital, Mt. Pleasant 48858
Remsberg, Richard J. (O)....309 State St., Alma 48801
Roth, Wm. J...............303 W. Superior, Alma 48801
Rottschaefer, John L.....3580 Northlawn Pk., Alma 48801
Rutt, Wilmer M...........310 Warwick Dr., Alma 48801
Sanders, Jack F.......Mich. Masonic Home, Alma 48801
Scott, Lincoln B., Jr.............R. 3, Mt. Pleasant 48858
Smith, Dennis V. (L)..............1435 Cambridge Rd., Ann Arbor 48104
Soriano, D. A.............Route #3, Mt. Pleasant 48858
Stack, Jack..............310 Warwick Rd., Alma 48801
Tilden, James F...Gratiot Community Hosp., Alma 48801
Veldhuis, Andrew H...801 Gordon Rd., Mt. Pleasant 48858
Waggoner, Richard L...712 Michigan Ave., St. Louis 48880
Wallman, C. Harry............901 State St., Alma 48801
Wickert, Leo R.....1001 Watson Rd., Mt. Pleasant 48858
Wilcox, Rex A.................525 State St., Alma 48801
Will, Theodore....314 S. Brown St., Mt. Pleasant 48858
Wilson, Earl C.........................Harrison 48625
Wilton, Robert E. (O)..320 W. Superior St., Alma 48801
Wolfe, Kenneth P.........510 Prospect Ave., Alma 48801
Wood, Cornelius B...........Route 2, Mt. Pleasant 48858
Wood, John M......1108 Watson Rd., Mt. Pleasant 48858

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P..............Olin Hlth. Center, MSU, East Lansing 48823
Davis, William B. ....55 Barry, Hillsdale 49242
Day, Luther W. (A)................311 E. Ocean Ave., Lantana, Fl. 33460
Gates, Jon H. (M)..................67th Tuslog Det, APO 09380, N.Y.
Henelt, Edmond............32 S. Broad, Hillsdale 49242
Hodge, Chas. L.........................Reading 49274
MacNeal, John A...........379 S. Broad, Hillsdale 49242
Mattson, H. Frazyer......32 S. Broad St., Hillsdale 49242
Peterson, Carl A.............59 Barry St., Hillsdale 49242
Powers, Ward O.......................Jonesville 49250
Reigle, Frederick C.....................Litchfield 49252
Sawyer, Walter W.......61 N. Howell St., Hillsdale 49242
Smith, Clark B............252 S. Howell, Hillsdale 49242
Stein, Arthur J...........144 Budlong St., Hillsdale 49242
Strom, Arthur W.........32 S. Broad St., Hillsdale 49242
Tarr, John...........................Camden 49232
Trapp, Donald G.........32 S. Broad St., Hillsdale 49242
Vear, Charles T.......252 S. Howell St., Hillsdale 49242
Wiggins, Ira W..........Box 5007, Cristobal, Canal Zone

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Aldrich, Addison B.......325 Harris Ave., Hancock 49930
Aldrich, Leonard C.......301 Quincy St., Hancock 49930
Barrios, Honorato.........424 Quincy St., Hancock 49930
Conner, William T.......146 Osceola St., Laurium 49913
DeCastilla, Pedro R.......424 Quincy St., Hancock 49930
Goodreau, Paul G.........301 Quincy St., Hancock 49930
Hillmer, Raymond E. (L).............Painesdale 49955
Janis, Anton J............208 Quincy St., Hancock 49930

Kolb, Fredk. E........128 Calumet Ave., Calumet 49913
La Bine, Alfred (L)......Masonic Bldg., Houghton 49931
La Core, Ivan A...Rice Memorial Clinic, Houghton 49931
Lanczy, Tamas O...Baraga County Hospital, L'Anse 49946
Larson, Forrest W..........322 Shelden, Houghton 49931
Lepisto, Victor E.........210 Quincy St., Hancock 49930
Meier, Maurice D.........1033 Mine St., Calumet 49913
Moyer, Carl A...........................Baraga 49908
Murphy, Percy J......121 Calumet Ave., Calumet 49913
Otto, Howard........St. Joseph Hospital, Hancock 49930
Parker, Thomas M. (M)............U. S. Naval Hosp., Portsmouth, Va. 23708
Repola, Kenneth L. 400 Maynard St. 704, Ann Arbor 48108
Roche, Andrew M............221 5th St., Calumet 49913
Rowe, Kenneth E.....107½ Calumet Ave., Calumet 49913
Rowell, Wilfred J. (R)..............Eagle Harbor 49951
Sandell, Samuel T..6 W. St. Andrews, Duluth, Minn. 55803
Sloan, Paul S.........609 Sheldon Ave., Houghton 49931
Stroube, John A............522 W. Third, L'Anse 49946
Williams, Marshall S...St. Joseph's Hospital, Hancock 49930
Winkler, Henry J................Box 461, L'Anse 49946

HURON COUNTY MEDICAL SOCIETY (86)

Brouillette, J. N...........106 Willis St., Bad Axe 48413
Dixon, Ralph C..................Box 77, Pigeon 48755
Elliott, Chas. S..........................Pigeon 48755
Herrington, C. Clark..117 S. Port Crescent, Bad Axe. 48413
Herrington, K. B.......317 Port Crescent, Bad Axe 48413
Jones, David L........206 Heisterman St., Bad Axe 48413
Kube, Kenneth S.......................Bad Axe 48413
Mullaney, J. M., Jr...108 S. Port Crescent, Bad Axe 48413
Oakes, Chas. W., Jr................Harbor Beach 48441
Oakes, Robert W.................7890 Sand Beach Rd., Harbor Beach 48441
Rady, Gordon R....206 N. Heisterman St., Bad Axe 48413
Scheurer, Clare A..........................Pigeon 48755
Sidagis, Joseph.........6 W. Main St., Sebewaing 48759
Sorensen, Maurice G............P. O. Box, Elkton 48731
Steinhardt, Edward E...Henry Ford Hosp., Detroit 48202
Turner, Phillip R.....230 S. First St., Harbor Beach 48441
Wible, Chas. F., Jr...................Sebewaing 48759
Willits, Robert A...........193 N. Main St., Elkton 48731

INGHAM COUNTY MEDICAL SOCIETY (90)

Adams, Charles......2909 E. Grand River, Lansing 48912
Agate, Geo. H.......Mich. Dept. of Hlth., Lansing 48906
Agustsson, Magnus H.............2025 W. Holmes Rd., Lansing 48910
Aiken, Donald J...Grandview & Grand Rv., Okemos 48864
Alexander, Reuben G.....701 N. Logan St., Lansing 48914
Allis, Harry D.......2909 E. Grand River, Lansing 48912
Altland, J. K...........Route 2, Box 178, Lansing 48917
Asselin, David C.......1322 E. Michigan, Lansing 48912
Badgley, Waldo O.....930 N. Washington, Lansing 48906
Baker, Thos. C........930 N. Washington, Lansing 48906
Bassett, Robt. C...1322 E. Michigan Ave., Lansing 48912
Bates, Richard.......2909 E. Grand River, Lansing 48912
Bauer, Theodore I (L)..........810 Mich. Nat. Tower, Lansing 48933
Behen, Wm. C. (L)..535 S. Capitol Ave., Lansing 48933
Behney, Charles A. (L)..........Box 4256 San Jose Dr., Bisbee, Az. 85603
Bellinger, Ernest G. (L)......Masonic Home, Alma 48801
Berden, Eleanor A......2630 Libbie Drive, Lansing 48917
Bergeest, Hans......1980 Tamarisk, East Lansing 48823
Bergeon, Milton C...1021 W. Dansville Rd., Mason 48854
Bethards, Rolland E.....Sparrow Hospital, Lansing 48902
Bevez, Frank L....3209 S. Cambridge Rd., Lansing 48910
Bingham, B. Wayne......1034 E. Saginaw, Lansing 48906
Black, Chas. E...........112 W. Allegan, Lansing 48933
Black, Gertrude C. K.............529 W. Grand River, Williamston 48895
Blair, Thomas C....1322 E. Michigan Ave., Lansing 48912
Bleil, Eugene E....1322 E. Michigan Ave., Lansing 48912
Bradford, Carl W.....832 Westlawn, East Lansing 48823
Briggs, James (A)..................Box 68, Holt 48842
Brown, Fredk. W., Jr...........831 N. Washington Ave., Lansing 48906
Brown, Joseph C. (A)..............Box 68, Holt 48842
Brubaker, Earl W. (L)..444 S. Verlinden, Lansing 48915
Budden, M. Arthur..2909 E. Grand River, Lansing 48912
Burge, Terry E. (A)................Box 68, Holt 48842
Byerrum, Mr. Richard U. (A)........602 Wildwood Dr., East Lansing 48823
Cairns, Donald A............P.O. Box 110, Mason 48854
Calomeni, Anthony D...1850 W. Mt. Hope, Lansing 48910
Carlson, Ralph G.........225 S. Waverly, Lansing 48917
Carr, Earl I. (L)..1915 Moores River Dr., Lansing 48910
Caruso, Joseph A........701 N. Logan St., Lansing 48915
Casey, Byron L........202 M. A. C., East Lansing 48823
Chaskes, Marian I. G...210 E. Hillsdale St., Lansing 48933
Chemycz, Joseph R....4930 Hillcrest Ave., Okemos 48864
Cheney, Wm. D.....Sparrow Hosp. X-ray, Lansing 48902
Chi, Seong H. (A)..Ingham Medical Hosp., Lansing 48910
Cipparone, Joseph R...St. Lawrence Hosp., Lansing 48914
Clark, Gaius D...865 Pebblebrook Ln., East Lansing 48823
Clark, Wm. E...............131 E. Oak St., Mason 48854
Clinton, Geo. R......................R. 2, Mason 48854
Clore, Forrest C. (M)
Collier, Beverly A......2210 Montego Dr., Lansing 48912
Collier, Richard L......2210 Montego Dr., Lansing 48912
Combs, Robert G...1023 E. Michigan Ave., Lansing 48912
Comstock, Howard C. 2909 E. Grand River, Lansing 48912
Conklu, Ilhan........401 W. Greenlawn, Lansing 48910
Cook, J. Maxwell.3911 W. Michigan Ave., Lansing 48917
Cope, Henry E. (R)...605 Westmoreland, Lansing 48915
Cordes, Jerome F.....2909 E. Grand River, Lansing 48912
Corneliuson, Goldie B. (R)........Rivergarden Apt. 58-E, 3225 E. Riverside Dr., Ft. Myers, Fla. 33901
Cowan, Daniel..................Dept. of Path., MSU, East Lansing 48823
Cowan, John A.........825 Touraine, East Lansing 48823
Crow, Harold E. 2909 E. Grand River Ave., Lansing 48912
Daugherty, Robert M.............599 Pebblebrook Lane, East Lansing 48823
Davis, Don G...........701 N. Logan St., Lansing 48915
Dawe, C. D......1515 W. Mt. Hope Ave., Lansing 48910
De Vries, Corydon F. (L)...........320 Townsend St., Lansing 48933
Dexter, Mary J. B. (A)......229 E. Maple, Mason 48854
Drolett, Alfred J. (L)..1018 Prudden Bldg., Lansing 48933
Drolett, Donald J...1322 E. Michigan Ave., Lansing 48912
Drolett, Lawrence A.....1036 Morris Ave., Lansing 48917
Dunkel, John F...Edw. W. Sparrow Hosp., Lansing 48902
Dunn, Forest M....1322 E. Michigan Ave., Lansing 48912
Edminster, Ralph R.........Sparrow Hosp. Path. Dept., Lansing 48902
Ellis, Bertha W. (R)...................P. O. Box 2327, Hollywood, Fl. 33022
Ellis, C. Ward (L)..P.O. Box 2327, Hollywood, Fla. 33022
Ellison, Alfred, Jr.............2909 E. Grand River 202, Lansing 48912
Enelow, Allen J.....936 Southlawn, East Lansing 48823
Feeney, Kenneth J. 1908 Mich. Natl. Tower, Lansing 48933
Feurig, James S.......321 Kensington, East Lansing 48823
Flory, Clyde R., Jr......201 W. Hillsdale, Lansing 48933
Folkers, Leonard M.................234 Michigan Ave., East Lansing 48823
Forbes, John D. (M)................301 Effingham St., Portsmouth, Va. 23704
Fortino, Silvio P.....2909 E. Grand River, Lansing 48912
Fryer, Douglas H....Mich. Dept. of Hlth., Lansing 48906
Garlinghouse, A. John., Jr.........1322 E. Michigan Ave., Lansing 48912

Gellar, Abraham........108 Division, East Lansing 48823
George, Harry C.........335 Seymour St., Lansing 48933
Ghannam, Rasem.......919 Chester Road, Lansing 48912
Ginnebaugh, L. A. (E)...2114½ N. Bond, Saginaw 48602
Goldner, Roy E. (A).........1318 S. Washington Ave., Lansing 48910
Govons, Sidney R...1322 E. Michigan Ave., Lansing 48912
Grey, Anna B. (L)....915 Cajon St., Redlands, Ca. 92373
Haddy, Theresa B..900 Audubon Rd., East Lansing 48823
Hames, R. E.......1322 E. Michigan Ave., Lansing 48912
Hanna, Roger J. (R)......329 E. South St., Mason 48854
Harrington, Louis E...3526 W. Saginaw St., Lansing 48917
Harris, Herbert W........919 Chester Rd., Lansing 48912
Harrison, Wm. H....834 W. St. Joseph St., Lansing 48915
Harrold, Jesse F...........326 W. Ionia, Lansing 48933
Hatton, R. L.........4462 Greenwood St., Okemos 48864
Hay, Kent R.......1322 E. Michigan Ave., Lansing 48912
Hayes, Robt. E.....1322 E. Michigan Ave., Lansing 48912
Hayford, Wm. D.....1028 E. Saginaw St., Lansing 48906
Heald, Gordon H...714 Abbott Road, East Lansing 48823
Heckert, Frank B. 1105 Bnk. of Lnsg. Bldg., Lansing 48933
Heckert, Jos. K. (L).........1105 Bnk. of Lnsg. Bldg., Lansing 48933
Heerdt, Mark E..........810 W. Saginaw, Lansing 48915
Henderson, Norman D..................726 Abbott Rd., East Lansing 48823
Henshaw, Dan M.................119 E. Grand River, East Lansing 48823
Heustis, Albert E. 1111 Michigan Ave., East Lansing 48823
Hill, Thos. B..........554 Durand St., East Lansing 48823
Himmelberger, R. J.......3624 Colchester, Lansing 48906
Hiscoe, D. Bonta....2909 E. Grand River, Lansing 48912
Hochglaube, Jacque............701 N. Logan, Suite 515, Lansing 48915
Hoffer, W. E. (L).....331 Shepard Street, Lansing 48912
Hogg, Raymond E....2909 E. Grand River, Lansing 48912
Holland, Chas. F.........810 W. Saginaw, Lansing 48915
Horvath, Francis..MSU Health Center, East Lansing 48823
Hoyt, John C........................Box 66, Holt 48842
Huggett, Clare C...122 W. Gd. River Ave., Lansing 48906
Hunt, Andrew D., Jr.........Coll. of Human Med., MSU, East Lansing 48823
Hurth, M. S..............1717 Jerome St., Lansing 48912
Imeson, Elizabeth W.................1809 Cahill Drive, East Lansing 48823
Isbister, J. L.....Dept. Health, DeWitt Rd., Lansing 48906
Iung, Omero S. (N).........411 Bartlett, Lansing 48915
Jacob, S. Sprigg, III.....201 Ann St., East Lansing 48823
Jakubiak, Paul.......1975 Bloomfield Dr., Okemos 48864
Jarstfer, Bruce S.. (M)........USA, Tripler Gen. Hosp., Honolulu, Hawaii 96819
Jason, Hilliard..............Olin Mem. Hlth. Ctr., MSU, East Lansing 48823
Johnson, David B.....2909 E. Grand River, Lansing 48912
Johnson, Georgia A. L...2608 Darien Dr., Lansing 48912
Johnson, Kenneth H. (L)........1116 Mich. Nat. Tower, Lansing 48933
Johnson, Lanny L. 903 E. Grand River, East Lansing 48823
Johnson, Richard..2909 E. Grand River 202, Lansing 48912
Jones, Francis A., Jr. (R)...........815 Royal Palm Pl., Vero Beach, Fl. 32960
Jones, Lester C...2909 E. Grand River 203, Lansing 48912
Jones, Martin F......2909 E. Grand River, Lansing 48912
June, Robt. C............209 N. Walnut, Lansing 48933
Kahn, David........2909 E. Grand River, Lansing 48912
Kalmbach, Roland E. (L)........1322 E. Michigan Ave., Lansing 48912
Katlein, Stanley............2231 Heritage, Okemos 48864
Kellerman, Howard H............1322 E. Michigan Ave., Lansing 48912
Kelly, William....1203 W. Oakland Ave., Lansing 48915
Kent, A. Edith Hall (L)........Box 1167, Lansing 48904
Kent, Herbert K. (L)..........Box 1167, Lansing 48904
Kenyon, Fanny H. (L)..624 LaSalle Blvd., Lansing 48912
Kinzel, Raymond C.......326 W. Ionia St., Lansing 48933
Klunzinger, W. R.........326 W. Ionia St., Lansing 48933
Knisely, Wm. H. (A)...............731 Oakwood Drive, East Lansing 48823
Kovich, Eleanore (A)................304 N. Shore Dr., St. Clair Shores 48080
Kozak, Jerome S.........919 Chester Rd., Lansing 48912
Kraft, Lester C............209 S. Main St., Leslie 49251
Landick, Robt. E., Jr.....810 W. Saginaw, Lansing 48915
Lange, Philip F......2025 W. Holmes Rd., Lansing 48910
Larkey, Paul E.......110 N. Rosemary St., Lansing 48917
Larson, Homer I....1322 E. Michigan Ave., Lansing 48912
Lauzun, Virginia D................1654 E. Grand River, East Lansing 48823
Le Duc, Don M....1322 E. Michigan Ave., Lansing 48912
Leshock, Jos. C.........701 N. Logan St., Lansing 48915
Levett, Harry L. 2909 E. Grand River Ave., Lansing 48912
Lewis, Alvin. .358 Giltner Hall—MSU, East Lansing 48823
Lewis, Clayton, Jr....2909 E. Grand River, Lansing 48912
Linnell, Paul C.............701 N. Logan, Lansing 48915
Llinas, Jose J.......Ingham Med. Hospital, Lansing 48910
Long, Chas. O., Jr....2909 E. Grand River, Lansing 48912
Loree, Maurice C.....120 W. Hillsdale St., Lansing 48933
Loughrin, Harry J...1005 Abbott Rd., East Lansing 48823
Loughrin, T. D......1005 Abbott Rd., East Lansing 48823
Lovoll, Kaare............209 N. Walnut, Lansing 48933
Lucas, Thos. A........1515 W. Mt. Hope, Lansing 48910
Ludlum, Lewis C.....1126 W. Saginaw St., Lansing 48915
Maldonado, W. E........Sparrow Hospital, Lansing 48902
Mandelstamm, Maria B.............4583 Comanche Dr., Okemos 48864
Mannausa, L. R...701 N. Logan, Ste. 630, Lansing 48915
Martin, Wayne O........4765 Nakoma Dr., Okemos 48864
Marzolf, M. Finette (N)..........3315 Wisconsin N.W., Washington, D.C. 20016
Mavromatis, E.....1322 E. Michigan Ave., Lansing 48912
Mavromatis, F.....1322 E. Michigan Ave., Lansing 48912
May, Stephen G. 202 M. A. C. Avenue, East Lansing 48823
McCorvie, C. Ray (L)..........525 N.E. Hayworth Rd., Port Charlotte, Fl. 33950
McCorvie, Donald R.............Williamston Med. Bldg., Williamston 48895
McElmurry, Leland R...209 N. Walnut St., Lansing 48933
McFarlane, Donald R............1322 E. Michigan Ave., Lansing 48912
McGillicuddy, O. B. (L)........1816 Mich. Natl. Tower, Lansing 48933
McKenney, Marvin J.............1322 E. Michigan Ave., Lansing 48912
Meade, Wm. H.........1023 E. Michigan, Lansing 48912
Meinke, Richard K. 1322 E. Michigan Ave., Lansing 48912
Melick, Richard C...........326 W. Ionia, Lansing 48933
Mercer, Walter E. (R) 909 Glenhaven, East Lansing 48823
Messenger, A. L....1322 E. Michigan Ave., Lansing 48912
Miller, J. T., Jr., Lt. Cmdr. MC USNR (M)..4307 Robert Court, Wheaton, Md. 20906
Miller, Willard J......225 S. Waverly Rd., Lansing 48917
Mirkil, V. Jerome.....1740 Foxcroft, East Lansing 48823
Molina-Pung, Elba..............Olin Hlth. Ctr., MSU, East Lansing 48823
Monfort, Robt. N. (R)..300 Pacific Rd., Miami, Fl. 33149
Moore, Charles R...1322 E. Michigan Ave., Lansing 48912
Moore, Donald B...1322 E. Michigan Ave., Lansing 48912
Morrow, Robt. J. (R)................741 S.W. 2nd St., Boca Raton, Fl. 33432
Nakfoor, Eugene C...1320 S. Genesee Dr., Lansing 48915
Neering, James C...1322 E. Michigan Ave., Lansing 48912
Neuman, John R......225 S. Waverly Rd., Lansing 48917
Newitt, A. W. (L) 1616 W. Michigan Ave., Lansing 48915
Nicholas, Mildred V. 5596 Portage Lake Rd., Dexter 48130
Niland, Paul T.....1322 E. Michigan Ave., Lansing 48912
Ochsner, Paul J. (R)...Fisher Body Corp., Lansing 48915
Ojeda, Pedro.....701 N. Logan, Suite 212, Lansing 48915
Packer, John H......2909 E. Grand River, Lansing 48912
Paine, Wm. G........1028 E. Saginaw St., Lansing 48906
Palmer, R. E. (L).................1627 Wildwood Rd., Clearwater, Fl. 33516
Parker, Earl E.............207 E. Bellevue, Leslie 49251
Payne, Thomas C.............2909 E. Grand River Ave., Lansing 48912
Peets, Ronald.....Gr. River & Grandview, Okemos 48864
Perry, Robert A..........701 N. Logan, Lansing 48915
Philips, David P. (R)..1217 Loraine Ave., Lansing 48910
Plant, John F........2909 E. Grand River, Lansing 48912
Plesscher, Wm. H...1322 E. Michigan Ave., Lansing 48912
Pomeroy, Richard W.......Sparrow Hosp., Lansing 48912
Powell, Gerald D.......1850 W. Mt. Hope, Lansing 48910
Prakash, Om.....1600 South Ave., Rochester, N.Y. 14620

Quigley, Donald R.......701 N. Logan St., Lansing 48915
Reizen, Maurice S...119 W. Washtenaw St., Lansing 48904
Reynolds, Edward E.....Rt. 2, Box 1B, Williamston 48895
Rice, R. G............3500 N. Logan St., Lansing 48914
Richards, Frank D...1322 E. Michigan Ave., Lansing 48912
Richardson, M. L. (L)....410 Albert, East Lansing 48823
Ringer, Edward L.......122 W. Hillsdale, Lansing 48933
Robinson, Thomas H.........P.O. Box 204, Lansing 48901
Robson, Edmund J.....215 N. Walnut St., Lansing 48933
Rollstin, Robt. A.......1014 Townsend St., Lansing 48933
Ruhmkorff, Ralph H. (R)...........MSU Health Center, East Lansing 48823
Rutledge, Saml. H., Jr...........1322 E. Michigan Ave., Lansing 48912
Saenz, Hugo R........1515 W. Mt. Hope, Lansing 48910
Saker, James H.......201 W. Hillsdale St., Lansing 48933
Sander, John F. (L)....4780 Okemos Rd., Okemos 48864
Scallin, J. F.............810 W. Saginaw, Lansing 48915
Scharphorn, James (A)...1050 Wall St., Ann Arbor 48105
Scheidt, R. Rudolph.....201 W. Hillsdale, Lansing 48933
Schmidt, Harry J.....2909 E. Grand River, Lansing 48912
Schultz, Arthur E.........2700 Mt. Hope, Okemos 48864
Seger, Fred L. (L)...............1035 Cherry St. N.E., St. Petersburg, Fl. 33701
Shapiro, Hyman D...1327 E. Michigan Ave., Lansing 48912
Sharp, Mahlon S.....2909 E. Grand River, Lansing 48912
Shaw, Milton (L)......320 Townsend St., Lansing 48933
Sheets, Joseph L.....2909 E. Grand River, Lansing 48912
Sherman, Geo. A. (L)...504 Cowley, East Lansing 48823
Sichler, Harper G. (R)............1476 Stonegate Lane, East Lansing 48823
Siegel, David........2909 E. Grand River, Lansing 48912
Silverman, Irving E...2909 E. Grand River, Lansing 48912
Sleight, Justin L......2909 E. Grand River, Lansing 48912
Smith, Anthony V........116 W. Sycamore, Mason 48854
Smookler, Bernard H. 2909 E. Grand River, Lansing 48912
Snyder, Le Moyne (R)....P.O. Box S, Paradise, Ca. 95969
Snyder, Ruth C. E...............234 W. Michigan Ave., East Lansing 48823
Spagnuolo, Alfred J.....1418 S. Logan St., Lansing 48910
Spencer, J. Clyde........Sparrow Hospital, Lansing 48902
Spencer, Perry C........320 Townsend St., Lansing 48933
Stanley, Arthur L......401 W. Greenlawn, Lansing 48910
Steiner, Abraham A. (R)....Route 3, Grand Ledge 48837
Stephan, Winton E.........432 S. Walnut, Lansing 48933
Stilwill, Geo. D.......2909 E. Grand River, Lansing 48912
Stimson, Paul R...119 E. Grand River, East Lansing 48823
Stone, Benj. J. (A)................736 Rosewood Ave., East Lansing 48823
Stow, Robt. M.......2909 E. Grand River, Lansing 48912
Strempek, Walter F.................726 Whitehills Dr., East Lansing 48823
Stringer, C. J. (R)....425 Walbridge, East Lansing 48823
Suhrland, Leif G.................Dept. of Med., MSU, East Lansing 48823
Sundell, Edwin C...1322 E. Michigan Ave., Lansing 48912
Swartz, Fredk. C......720 Seymour Street, Lansing 48906
Tamblyn, Fredk. W.....335 Seymour Ave., Lansing 48933
Thaden, D. W.......909 Abbott Rd., East Lansing 48823
Thimmig, Robt. F...1322 E. Michigan Ave., Lansing 48912
Tien, Hsin Chen........701 N. Logan St., Lansing 48915
Trager, Fredk. C...1322 E. Michigan Ave., Lansing 48912
Trescott, Robt. F...1322 E. Michigan Ave., Lansing 48912
Trimby, Robt. H...1322 E. Michigan Ave., Lansing 48912
Troost, Franklin L. (L)...4378 W. Delhi Rd., Holt 48842
Turner, Paul C.............2909 E. Grand River, #203, Lansing 48912
Urban, Eva...........540 Glenmoor, East Lansing 48823
Vanderzalm, T. P. (L)............1452 Cambridge Rd., Lansing 48910
Varner, Carol......Okemos Medical Bldg., Okemos 48864
Velten, Hubert P...1394 Red Leaf Ln., East Lansing 48823
Venier, Jos. H. 1628 Hitching Post Rd., East Lansing 48823
Wadley, Ralph (R)................Harbor Springs 49740
Walker, Leo W.....4225 Apple Tree Lane, Lansing 48917
Weber, William.......401 W. Greenlawn, Lansing 48910
Wellman, John M...1322 E. Michigan Ave., Lansing 48912
West, Chas. Carl.....2909 E. Grand River, Lansing 48912
Wiegenstein, John G...St. Lawrence Hosp., Lansing 48914
Wilcox, K. R., Jr....Mich. Dept. of Health, Lansing 48906
Wilensky, Thos.........701 N. Logan St., Lansing 48915
Wiley, D. Bruce (L)............921 Coolidge, Apt. 3, Lansing 48912
Willson, Howard S. (L)..........704 Mich. Nat. Tower, Lansing 48933
Worthington, Ralph......810 W. Saginaw, Lansing 48915
Wortley, Chas. K.................1017 E. Grand River, East Lansing 48823
Zick, Gerald A.....1322 E. Michigan Ave., Lansing 48912
Ziel, Hermann A., Jr.............Mich. Dept. of Health, Lansing 48906

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

Anderson, D. Hess........207 Bridge St., Portland 48875
Bautista, Leandre I......910 E. Lincoln Ave., Ionia 48846
Bennett, W. Bruce....Lakeview Hospital, Lakeview 48850
Bird Wm. L...........917 W. Oak St., Greenville 48838
Birzgalis, Alfreds A........Ionia State Hosp., Ionia 48846
Buck, Jack H..................517 Division, Ionia 48846
Bunce, Leo W...........................Trufant 49347
Campbell, Richard E...........104 S. Kidd, Ionia 48846
Colon-Bonet, Cesar H..............Lakeview Med. Ctr., Lakeview 48850
Dunkin, Lloyd S........410 S. Clay St., Greenville 48838
Foust, Jos. C. (A)................Kisa Box 73 Tukuyu, Tanganyika, E. Africa
Geib, Oscar P. (L).......................Gaylord 49735
Halick, John...........200 S. Franklin, Greenville 48838
Hansen, Carl M........................Stanton 48888
Haskell, Robt. H. (L)..........Zetlands Estate T.W.R., Nevis, Leeward Isl., B.W.I.
House, Glenn W., Jr....1200 W. Oak St., Greenville 48838
Kazmers, Nikolas.......................Lakeview 48850
Kopchick, Jos.............................Muir, 48860
Kozachik, Martin J.........123 Bridge St., Portland 48875
Leach, Russell E................Route #3, Ionia 48846
London, John L...Lakeview Medical Ctr., Lakeview 48850
Marston, Leo L...............Box 235, Lakeview 48850
Merchun, Frank A............11804 W. Carson City Rd., Greenville 48838
Mitchell, Harold C. (R).............Box 3175 Nalcrest, East Lake Wales, Fl. 33853
Naglins, Jekabs...........Ionia State Hosp., Ionia 48846
Olsen, Bruce C.........917 W. Oak St., Greenville 48838
O'Malley, R. J.................310 Main St., Ionia 48846
Pates, Don C............122 E. Congress, Belding 48809
Rice, Robt. E.........420 S. Bower St., Greenville 48838
Robertson, Perry C. (L)......327 Center St., Ionia 48846
Rottman, G. Jay....6413 N. Lafayette, Greenville 48838
Sanford, Louis E............219 Main St., Belding 48809
Slagh, Milton E.........................Saranac 48881
Smith, Robt. O..........910 E. Lincoln Ave., Ionia 48846
Socha, Edmund S..............217 E. Main, Ionia 48846
Stevens, Charles E...513 N. Lafayette St., Greenville 48838
Tannheimer, John F........525 Lafayette St., Ionia 48846
Younis, Ahmad.....505 S. Lafayette St., Greenville 48838

JACKSON COUNTY MEDICAL SOCIETY (98)

Adams, Ellis W..........720 W. Franklin, Jackson 49201
Ahronheim, Gerald (M)..........TDY 6168th Air Base, APO San Francisco, Calif...96213
Ahronheim, J. H.....Foote Memorial Hosp., Jackson 49201
Allen, Duane M.....Hanover Medical Ctr., Hanover 49241
Appel, Saul........112 W. Michigan Ave., Jackson 49201
Argun, Turan.....762 W. Michigan Ave., Jackson 49201
Baker, Geo. M...............350 S. Union, Parma 49269

Beckwith, Sidney A....100 E. Main St., Stockbridge 49285
Bentley, Jack P.....2532 Spring Arbor Rd., Jackson 49203
Bentley, Mary E. N., 2532 Spring Arbor Rd., Jackson 49203
Betts, Joseph S..52 Brigham St., New Bedford, Mass. 02741
Booth, Jerry B. DDS (A).........766 W. Michigan Ave., Jackson 49201
Brashares, Zane A.......................Brooklyn 49230
Bullen, G. R. (L)..........418 Third St., Jackson 49201
Buslepp, Robert C.....901 Reynolds Bldg., Jackson 49201
Celis, F. T.......766 W. Michigan Ave., Jackson 49201
Clarke, Corwin S. (L) Hacinda Carmel, Carmel, Ca. 93921
Cooley, Chas. W.............Mercy Hosp., Jackson 49201
Corley, Cecil (L).....204 Homecrest Rd., Jackson 49201
Corley, Ennis H. (L)..1401 Reynolds Bldg., Jackson 49201
Corley, Robt. W......1401 Reynolds Bldg., Jackson 49201
Daly, Byrne M..........297 W. Michigan, Jackson 49201
Davenport, Bruce............612 First St., Jackson 49203
De May, Cuthbert E. (L).........403 E. Michigan Ave., Jackson 49201
De May, John D.....403 E. Michigan Ave., Jackson 49201
Deming, Richard C.......724 W. Franklin, Jackson 49201
Douglas, Edward W. (L)..1920 Fourth St., Jackson 49203
Filip, Hypolit K.........502 Lansing Ave., Jackson 49201
Finton, Robt. E.........610 W. Michigan, Jackson 49201
Foley, Hugh B...Mercy Hosp. Pathology, 524 Lansing Ave., Jackson 49201
Greenbaum, Harry...1203 Greenwood Ave., Jackson 49201
Growt, Bowers H. (L)..................Addison 49220
Habenicht, Hilda A......545 Lansing Ave., Jackson 49201
Hackett, Thos. L.........519 N. East Ave., Jackson 49202
Hardie, Geo. C..........724 W. Michigan, Jackson 49201
Hicks, Glenn C. (L)............1009 Wildwood Avenue, Jackson 49202
Hoffman, Howard C.........612 First St., Jackson 49203
Holst, John B.........606 City Bank Bldg., Jackson 49204
Huldin, Donald H...........1514 Fourth, Jackson 49203
Jennings, Larry E...766 W. Michigan Ave., Jackson 49201
Joerin, Wm. A.........720 W. Franklin St., Jackson 49201
Karr, Jean P.......502 W. Michigan Ave., Jackson 49201
Keefer, Albert H.......................Concord 49237
Keeler, Clifford E.........2017 Fourth St., Jackson 49203
Kiessling, A. J., Jr.......511 S. West Ave., Jackson 49203
Kobs, Robt. J.........720 W. Franklin St., Jackson 49201
Kopp, Clemens M.................Port Huron Hospital, Port Huron 48060
Krawczyck, Boleslaw............Box 806, Jackson 49201
Lake, Edward C.......720 W. Franklin St., Jackson 49201
Landron, Daniel......4633 Page, Michigan Center 49254
Latchaw, William R......4000 Cooper St., Jackson 49201
Lenz, Chas. R., Jr.............405 1st St., Jackson 49201
Lewis, Elmore F. (L)..1112 Carlton Blvd., Jackson 49203
Linden, Victor E..........2025 Fourth St., Jackson 49203
Ludwick, John E. (L)..........Lake Cecile Dr., R#2, Kissimmee, Fl. 32741
Ludwick, John P......237 W. Washington, Jackson 49201
Maas, Gerald I........1615 Carlton Blvd., Jackson 49203
McGarvey, Wm. E. (L)..........161 W. Michigan Ave., Jackson 49201
McLaughlin, John M.....710 S. Brown St., Jackson 49203
McLaughlin, Miar J. (L)..710 S. Brown St., Jackson 49203
McLauthlin, H. B.......1123 S. Brown St., Jackson 49203
McQuillan, F. P...........611 Center St., Jackson 49202
Meads, Jason B. (L) 161 W. Michigan Ave., Jackson 49201
Medlar, Robt. E.......719 Seventeenth St., Jackson 49203
Michaud, A. J.........204 Homecrest Rd., Jackson 49201
Morelli, Lorenzo......401 W. Prospect St., Jackson 49203
Muhich, Ralph A...2532 Spring Arbor Rd., Jackson 49203
Munro, Nathan D...740 W. Michigan Ave., Jackson 49201
Murphy, Bernard M....1134 E. Ganson St., Jackson 49201
Newton, Ray E. (L) 180 W. Michigan Ave., Jackson 49201
Nichols, Don H. (M)...703 S. Webster St., Jackson 49203
Niekamp, Harold....762 W. Michigan Ave., Jackson 49201
Oleksy, Stanley P........744 W. Michigan, Jackson 49201
Olsen, Lloyd L.....610 W. Michigan Ave., Jackson 49201
Oster, Harold L..........1514 Fourth St., Jackson 49203
Otis, Grant L..........525 Wildwood Ave., Jackson 49201
Parker, John C.......610 N. West Avenue, Jackson 49202
Payne, Andrew K...Foote Memorial Hosp., Jackson 49201
Phillips, Geo. H...Jackson Co. T. B. Sanat., Jackson 49202
Pray, Frank F. (L)...........6533 Woodward Lake Rd., Fenwick 48834
Reizner, Bernard Z..........611 Hill Rd., Marshall 49068
Rice, John W.............421 McNeal St., Jackson 49203
Ries, Richard G.........720 W. Franklin St., Jackson 49201
Riley, Philip A. (L)....500 S. Jackson St., Jackson 49203
Riley, Philip A., Jr......500 S. Jackson St., Jackson 49203
Rodriquez, Leopoldo..810 W. Saginaw St., Lansing 48915
Rua, Ignacio...............1810 W. High, Jackson 49203
Rucker, Joseph..........1012 Francis St., Jackson 49203
Sargent, Leland E...Foote Memorial Hosp., Jackson 49201
Sautter, Wm. A..........................Horton 49246
Schmidt, Theophile E. (L)........180 W. Michigan Ave., Jackson 49201
Schneider, R. H..........724 W. Franklin, Jackson 49201
Schrader, Frank J.......502 Lansing Ave., Jackson 49201
Scott, John A., Jr........432 W. Michigan, Jackson 49201
Shaeffer, Leland D......1615 Carlton Blvd., Jackson 49203
Sher, David B. (R)........3800 Kirkwood, Jackson 49203
Sill, Henry W.......724 W. Michigan Ave., Jackson 49201
Sirhal, Alfred M.......................Brooklyn 49230
Smith, Dean W.....500 W. Michigan Ave., Jackson 49201
Stackable, Wm. R...2532 Spring Arbor Rd., Jackson 49203
Stewart, Lewis L., Jr.....1919 Kibby Rd., Jackson 49203
Stolberg, Carl A..........724 W. Franklin, Jackson 49201
Stone, Ethon L.......721 Seventeenth St., Jackson 49203
Sugar, Saml.........762 W. Michigan Ave., Jackson 49201
Tate, Cecil E......2400 W. Michigan Ave., Jackson 49202
Taylor, Lee E. (M) 7481 A Darnall St., El Paso, Tx. 79930
Taylor, Ross V........517 Wildwood Ave., Jackson 49201
Thalner, Leonard F. (L)..........609 W. Michigan Ave., Jackson 49201
Thayer, Earl A. (L) 120 W. Michigan Ave., Jackson 49201
Thompson, T. B.......434 Wildwood Ave., Jackson 49201
Townsend, James W. (L)..............108 Hague Ave., Vandercook Lake, Jackson 49203
VanSchoick, Frank...........2100 4th St., Jackson 49203
VanSchoick, R. M.....1731 Thornwood Rd., Jackson 49203
VanWagnen, F. I., Jr...434 Wildwood Ave., Jackson 49201
Vivirski, Edward E.......603 S. Elm Ave., Jackson 49203
Waeschle, Richard K......2100 Fourth St., Jackson 49203
Weddon, Edward R........R. F. D. 2, Stockbridge 49285
Wholihan, John W...604 W. Michigan Ave., Jackson 49201
Wickham, Woodward A......2029 Fourth, Jackson 49203
Wille, Warren S.....5325 Brown Lake Rd., Jackson 49203
Wittman, Thomas S., DDS (A)....761 W. Michigan Ave., Jackson 49201

KALAMAZOO ACADEMY OF MEDICINE (102)

Aach, Hugo A. (R)....3623 Duke St., Kalamazoo 49001
Ajemian, Edward P....252 E. Lovell St., Kalamazoo 49006
Alexander, C. A.......118 W. North St., Kalamazoo 49007
Alkema, H. Dale......252 E. Lovell, Kalamazoo 49004
Amundson, Martin E.............Health Center, WMU, Kalamazoo 49003
Andrews, Sherman E......935 John St., Kalamazoo 49001
Andrews, Thomas E...............1634 Gull Rd., #207, Kalamazoo 49001
Angell, Howard H. (A)..............Upjohn Company, Kalamazoo 49006
Anglin, Walter M. (A).............7211 Lantollary Rd., Kalamazoo 49004
Appel, Ben A.........252 E. Lovell St., Kalamazoo 49006
Appel, William.......252 E. Lovell St., Kalamazoo 49006
Appell, Lloyd E................126 N. Kalamazoo Ave., Vicksburg 49097
Armstrong, Robt. J........P.O. Box 22, Kalamazoo 49005
Aydogan, Enver.......1141 S. Rose St., Kalamazoo 49001
Banner, Lawrence R.............Kalamazoo State Hosp., Kalamazoo 49003
Barrows, Winona M...1500 Blakslee St., Kalamazoo 49007
Barry, Manley L.........Plainwell Sanit., Plainwell 49080
Bateman, William T.....914 S. Burdick, Kalamazoo 49001
Bennett, Keith F......252 E. Lovell St., Kalamazoo 49006
Benson, H. Curtis................217 Bronson Med. Ctr., Kalamazoo 49006

Berglund, Thomas R. . 6646 Portage Rd., Kalamazoo 49002
Berglund, V. A. . . . . . . 6646 Portage Rd., Kalamazoo 49002
Berry, Ivor, Jr. . . . . 516 Whites Rd., Kalamazoo 49001
Betz, Eldean G. . . . . 1711 Merrill, Kalamazoo 49001
Birch, Wm. G. . . . . 252 E. Lovell St., Kalamazoo 49006
Bodmer, Harvey C. . . . . 403 W. Kalamazoo Ave., Kalamazoo 49006
Bower, Richard J. . . . . 6646 Portage Rd., Kalamazoo 49002
Breneman, James C. . . . . 25 Pearl St., Galesburg 49053
Brooks, Carter D. (A) . . . . Upjohn Company, Kalamazoo 49001
Brue, Peter P. . . . . . 1009 Cambridge Dr., Kalamazoo 49001
Burdick, Harry W. . . . . 1219 S. Park St., Kalamazoo 49001
Burrell, Robt. B. . . . . 1711 Merrill St., Kalamazoo 49001
Butler, Wm. J. . . . . 1631 Gull Rd., Kalamazoo 49001
Callander, C. Glen. . . . 252 E. Lovell St., Kalamazoo 49006
Carter, E. R. . . . . 1324 S. Park St., Kalamazoo 49001
Cartland, Geo. F., Ph.D. (A) . . . . 1704 Dover Rd., Kalamazoo 49001
Cashen, Russell M. . . . . 252 E. Lovell St., Kalamazoo 49006
Chipps, Ronald S. . . . 1017 Eldridge Dr., Kalamazoo 49007
Chodos, Dale D. J. (A) . . . . Upjohn Company, Kalamazoo 49006
Chrest, Clarence P. . . . . 458 W. South St., Kalamazoo 49006
Christian, Daniel K. . . . . 252 E. Lovell St., Kalamazoo 49006
Clement, F. L. . . 502 Bronson Med. Cen., Kalamazoo 49006
Conrad, Maynard M. . . 252 E. Lovell St., Kalamazoo 49006
Cooper, Paul F. . . . . 252 E. Lovell St., Kalamazoo 49006
Cornish, F. L., III . . . . 1631 Gull Rd., Kalamazoo 49001
Cox, Franklin . . . . Borgess Hospital, Kalamazoo 49001
Crawford, Kenneth L. . . . . . 612 Douglas, Kalamazoo 49007
Crawley, Kenneth R. (A) . . . . Upjohn Company, Kalamazoo 49006
Creager, Ray O. . . . 1218 Bronson Circle, Kalamazoo 49001
Cretsinger, Francis C. . . . . . 935 John St., Kalamazoo 49001
Croasdale, R. E. . . . . . . 252 E. Lovell St., Kalamazoo 49006
Curran, Cyril J. . . . . Borgess Hospital, Kalamazoo 49001
Currier, Richard K. . . . 6646 Portage Rd., Kalamazoo 49002
Dahlstrom, Doris E. . . . . . . Route 1, Hickory Corners 49060
Decker, Wm. A. . . . . 1207 Oakland, Kalamazoo 49001
DeHaan, Raymond M. (A) . . . . Upjohn Company, Kalamazoo 49006
DeLong, Robt. E. . . . . 1634 Gull Rd., Kalamazoo 49001
DePree, Harold E. . . . . 252 E. Lovell St., Kalamazoo 49006
DeVries, John M. . . . . . . 516 Whites Rd., Kalamazoo 49001
Dew, Robt. R. . . . . 1711 Merrill St., Kalamazoo 49001
DeWitt, Norman L. (R) . . . . 5131 M-43, Box 77A, Hickory Corners 49060
Dick, Leo A. . . . . 1700 Gull Rd., Kalamazoo 49001
Dorner, Kenneth R. . . . . 220 Bronson Med. Center, Kalamazoo 49006
Dowd, Bennard J. . . . . 1700 Gull Rd., Kalamazoo 49001
Doyle, Fredk. M. (R) . . . . 3320 Bronson Blvd., Kalamazoo 49001
Fabi, Robert . . . . 1631 Gull Rd., Kalamazoo 49001
Fath, August F. . . . . 1631 Gull Road, Kalamazoo 49001
Ferguson, Robt. K. . . . . 1141 S. Rose St., Kalamazoo 49001
Finton, Max A. . . . . P.O. Box 368, Northport 49670
Fitzsimmons, F. J. . . . . GMC Div., 5200 E. Cork St., Kalamazoo 49002
Flunt, Roman . . . . Box A, Kalamazoo St. Hos., Kalamazoo 49003
Fopeano, John V. . . . . . . 1711 Merrill St., Kalamazoo 49001
Fosmoe, Robert J. . . . . 458 W. South St., Kalamazoo 49006
Fry, J. William. . . . . 1821 Whites Rd., Kalamazoo 49001
Fuller, Paul M. (R) . . . . . 1700 Gull Rd., Kalamazoo 49001
Gardner, Carl A. . . . . . . 1141 S. Rose St., Kalamazoo 49001
Geis, Arthur F. . . . . 1223 S. Park St., Kalamazoo 49001
Gerard, Earl S. (A) . . . . 3410 Runnymede Dr., Kalamazoo 49001
Gerstner, Richard M. . . . . 212 Bronson Med. Ctr., Kalamazoo 49006
Gibson, Richard E. Schoolcraft 49087
Gladstone, Wm. S. . . . . 458 W. South St., Kalamazoo 49006
Glaser, Danl. F. . . . . . . 463 Academy St., Kalamazoo 49006
Goodhue, Lolita G. (L) . . . . 905 A Menlo Ave., Menlo Park, Calif. 94025
Gove, Robert S. . . . . 1631 Gull Rd., Kalamazoo 49001
Grabowski, Walter. . . . . Box A, Kalamazoo St. Hosp., Kalamazoo 49003
Graf, Michael. . . . . 1634 Gull Road, Kalamazoo 49001
Grekin, Robt. H. . . . . 417 Forest St., Kalamazoo 49001
Gremel, Norman . . . . . . 458 W. South St., Kalamazoo 49006
Haddock, D. A., Jr. . . . . 6646 Portage St., Kalamazoo 49002
Hagans, James A. (A) Upjohn Company, Kalamazoo 49006
Hailman, Harold F. . . . . P.O. Box 430, Yonkers, N.Y. 10702
Hammer, John M. . . . . . . 100 Maple St., Parchment 49004
Hanson, Curtis M. . . . . 403 Bronson Mdcl. Ctr., Kalamazoo 49006
Hare, J. Donald. . . . . . 516 Whites Road, Kalamazoo 49001
Harrell, Frank G. . . . . 1602 Gull Rd., Kalamazoo 49001
Harrelson, Wm. D. . . . . 1324 S. Park, Kalamazoo 49001
Hayner, Russell A. . . . . 4015 Portage, Kalamazoo 49001
Heersma, H. Sidney. . . . 1711 Merrill St., Kalamazoo 49001
Heinle, Robt. W. Med. Div., Upjohn Co., Kalamazoo 49006
Hendrix, J. W. . . . . 515 Fineview, Kalamazoo 49007
Herbert, Walter N. . . . 1223 S. Park St., Kalamazoo 49001
Herendeen, Donald E. . . . 1219 S. Park, Kalamazoo 49001
Hersey, E. Freeman. . . . . 1215 Oakland Drive, Kalamazoo 49001
Hersey, Margaret S. . 1215 Oakland Dr., Kalamazoo 49001
Hildreth, Roscoe C. . . . 458 W. South St., Kalamazoo 49006
Hodges, Ralph M. . . . . 1631 Gull Rd. 209, Kalamazoo 49001
Hodgman, Albert B. . . 612 Douglas Ave., Kalamazoo 49007
Hodgman, Richard W. 612 Douglas Ave., Kalamazoo 49007
Hoekstra, George J. . . . . . . 100 Maple St., Parchment 49004
Howard, Willard H. . . . . . 1536 Gull Rd., Kalamazoo 49001
Hubbard, Edwin M. . . 252 E. Lovell St., Kalamazoo 49006
Hudson, A. Thomas . . . . 1631 Gull Rd. #201, Kalamazoo 49001
Hume, Robt. H. . . . . 1711 Merrill St., Kalamazoo 49001
Hunt, Jack . . . . 1631 Gull Rd., Kalamazoo 49001
Huyser, Wm. C. (L) . . 427 S. Burdick St., Kalamazoo 49006
Irwin, Wm. D. (L) . . 103 N. Burdick St., Kalamazoo 49006
Janke, Robert A. . . . 1821 Whites Dr. W., Kalamazoo 49001
Jennings, Robt. M. . . . . Box A, Kala. State Hosp., Kalamazoo 49003
Johnson, Fenimore T. (A) . . . . Med. Div., Upjohn Co., Kalamazoo 49006
Johnson, Harold C. A. . . . . 211 Bronson Medical Ctr., Kalamazoo 49006
Kadrnka, Frank O. (A) . . . . Upjohn Company, Kalamazoo 49006
Kapik, Armand. . . . . 1521 Gull Rd., Kalamazoo 49001
Kavanaugh, John. . . . . . 1634 Gull Road, Kalamazoo 49001
Kavanaugh, T. E. . . . . . . 1634 Gull Road, Kalamazoo 49001
Kavanaugh, Wm. R. . . 612 Douglas Ave., Kalamazoo 49007
Keep, Pliny M. . . . . 1521 Gull Rd., Kalamazoo 49001
Kettunen, Robert C. . . 252 E. Lovell St., Kalamazoo 49006
Kihm, John L. . . . . 1219 S. Park St., Kalamazoo 49001
Kilgore, Robt. N. . . Vet. Admin. Ctr., Prescott, Ariz. 86301
Kincaid, Joseph E. . . . . . . 1634 Gull Rd., Kalamazoo 49001
Klerk, Wm. J. . . . . 914 S. Burdick, Kalamazoo 49001
Koestner, Paul A. . . . . . . 1303 Portage St., Kalamazoo 49001
Kokales, Evan P. . . Western Mich. Univ., Kalamazoo 49003
Kube, William J. . . . . . . 1219 S. Park St., Kalamazoo 49001
Lawrence, James O. (A) . . . . 1409 Henderson Dr., Kalamazoo 49007
Lawson, James B. (A) . . R.R. 1, Box 190, Vicksburg 49097
Lemmer, Richard A. . . 252 E. Lovell St., Kalamazoo 49006
Littig, John D. . . . . 1324 S. Park St., Kalamazoo 49001
Littlejohn, P. M. . . 5111 Woodmont Dr., Kalamazoo 49001
Locklin, W. Kaye. . . . . 1141 S. Rose, Kalamazoo 49001
Louisell, James M. . . . . 611 Whitcomb St., Kalamazoo 49001
Lowe, W. Carter. . . . . . 252 E. Lovell St., Kalamazoo 49006
Loynd, James W., II. . 1141 S. Rose St., Kalamazoo 49001
Lubavs, Konrads V. . . . . . . 420 John St., Kalamazoo 49006
MacDonald, M. A. . . . . 252 E. Lovell St., Kalamazoo 49006
Machin, Harold A. . . . . 420 John St., Kalamazoo 49006
MacVicar, James E. . . . . 252 E. Lovell St., Kalamazoo 49006
Malone, James G. . . . . 420 John St., Kalamazoo 49006
Margolis, Fredk. J. . . 2901 S. Westnedge, Kalamazoo 49001
Marshall, Don. . . . 301 Bronson Med. Ctr., Kalamazoo 49006
Marshall, Wm. P. 211 Bronson Med. Ctr., Kalamazoo 49006
May, Donald G. . . . . 1634 Gull Rd., Kalamazoo 49001
McCarthy, James H. . . . . . . 100 Maple St., Parchment 49004
McCarthy, Jos. S. (L) . . . 1631 Gull Rd., Kalamazoo 49001
McColl, John A. . . . . 1634 Gull Rd., Kalamazoo 49001
McConnell, Richard R. 458 W. South St., Kalamazoo 49006
Mellis, Richard. . . . . . 611 Whitcomb St., Kalamazoo 49001
Merriman, Richard C. . . . 516 Whites Rd., Kalamazoo 49001

Moe, Carl R. . . . . .1324 S. Park St., Kalamazoo 49001
Mohney, Russell E., Jr. . .1631 Gull Rd., Kalamazoo 49001
Molony, Basil A. (M) . . . . .8503 Crown Place, Alexandria, Va. 22308
Morter, Roy A. (L) . . . . . .2421 Sheffield, Kalamazoo 49001
Murdy, Robert C. (R) . . . . .310 S. Kendall, Apt. 43, Kalamazoo 49007
Neerken, Adrian J. . . . . .404 Bronson Med. Ctr., Kalamazoo 49001
Nicholson, Robt. M. . . . . . .1711 Merrill, Kalamazoo 49001
Novak, Ervin (A) . . .Upjohn Company, Kalamazoo 49001
Ong, George H. . . . . .5820 S. 12th St., Kalamazoo 49001
Overbey, Chas. B., Jr. . . . . . .Box A, Kalamazoo St. Hosp., Kalamazoo 49003
Patmos, Martin . . . . . . .252 E. Lovell St., Kalamazoo 49006
Peake, Chas. O., III . . .252 E. Lovell St., Kalamazoo 49006
Pearson, Edwin O. . . . .458 W. South St., Kalamazoo 49006
Peelen, J. W. . . . . .516 Whites Rd., Kalamazoo 49001
Peelen, Matthew . . . . . .252 E. Lovell St., Kalamazoo 49006
Perry, Clifton W. . . . . . .1711 Merrill St., Kalamazoo 49001
Pinkham, Raymond A. 611 Whitcomb St., Kalamazoo 49001
Pool, John D. . . . . .202 Bronson Med. Center, Kalamazoo 49006
Powley, Gerald W. . . . . .1711 Merrill St., Kalamazoo 49001
Pritchard, Harold M. . . . . .Health Center, WMU, Kalamazoo 49003
Proos, Richard A. . .Western Mich. Univ., Kalamazoo 49003
Pullon, Alton E. . . . . . . .1223 S. Park St., Kalamazoo 49001
Rasmussen, Leo B. . . . .152 N. Main St., Vicksburg 49097
Reames, Harold R. . .2901 S. Westnedge, Kalamazoo 49001
Reigel, Thomas J., Jr. . . . . .2019 Rambling Rd., Kalamazoo 49001
Rigterink, Gerald H. . .433 South Rose St., Kalamazoo 49006
Roberts, Millard S. . . . . . . .1631 Gull Rd., Kalamazoo 49001
Robison, Walter A. . . . . .Health Center, WMU, Kalamazoo 49003
Rockwell, Donald C. (L) 1227 Jefferson, Kalamazoo 49007
Roesler, Hugo K. . . . . . .1141 S. Rose St., Kalamazoo 49001
Rogers, Rodney J. . . . .126 N. Kalamazoo, Vicksburg 49097
Roty, August R., Jr. . . . . . .252 E. Lovell, Kalamazoo 49006
Ruoff, Gary . . . . . .1416 W. Milham Rd., Kalamazoo 49002
Russcher, Allan H. . . . . . . .252 E. Lovell, Kalamazoo 49006
Ryan, Fredk. C. . .Kalamazoo State Hosp., Kalamazoo 49003
Rye, Wm. A. . . . . .Upjohn Company, Kalamazoo 49006
Sage, Edward D. (L) . . . . .902 Hanselman Bldg., Kalamazoo
Samuels, Solomon K. . . . . .935 John St., Kalamazoo 49001
Sassaman, F. W. . . . . .301 Bronson Medical Ctr., Kalamazoo 49006
Schaefer, Donald S. . . . . . .1324 S. Park, Kalamazoo 49001
Scherer, Flora E. (A) . . . . .Box A, Kala. State Hosp., Kalamazoo 49003
Scholl, James W. . . . . .1634 Gull Rd., Kalamazoo 49001
Scholten, Roger A. . . . .252 E. Lovell St., Kalamazoo 49006
Schrieber, R. S., Ph.D. (A) . . . . .Upjohn Company, Kalamazoo 49006
Schrier, Clarence T. M. . . . . .1000 Oakland Dr., Kalamazoo 49001
Schut, Almon L. . . . . .401 Bronson Med. Center, Kalamazoo 49006
Schwallie, Paul C. (A) . . . . .483 Sunrise Circle, Kalamazoo 49001
Simpson, Bernard W. . .610 So. Burdick, Kalamazoo 49006
Skellenger, Wm. S. . .2019 Rambling Rd., Kalamazoo 49001
Slatmyer, Karel R., Jr. . . . . .211 Bronson Mdcl. Ctr., Kalamazoo 49006
Smith, Roger J. . . . . .529 Park St., Parchment 49004
Sofen, Morris B. . .107 W. Michigan Ave., Kalamazoo 49006
Springgate, R. R. . . . . .1631 Gull Rd., Kalamazoo 49001
Steele, Frank M. . . . . . . .1521 Gull Rd., Kalamazoo 49001
Stewart, R. B. . . .211 Bronson Mdcl. Ctr., Kalamazoo 49006
Stewart, Wm. C., Jr. 2019 Rambling Rd., Kalamazoo 49001
Stieglitz, L. D. . . . . .218 W. Inkster, Kalamazoo 49001
Stiller, Anthony F. (R) . . . . .1235 N. Hillandale Dr., Kalamazoo 49001
Stilwell, James R. . .1002 S. Tenth St., Tacoma, Wa. 98405
Stryker, Homer H. (L) . . . . . .420 Alcott, Kalamazoo 49001
Stubbs, Samuel S. (A) . .1342 Lama Rd., Kalamazoo 49001
Swann, Raymond O. . .611 Whitcomb St., Kalamazoo 49001
Talanda, Edmund . . . . . . .3125 W. Main, Kalamazoo 49007
Townsend, Charles W. . . . . .723 S. Westnedge, Kalamazoo 49007
Upjohn, E. Gifford. . . .Upjohn Company, Kalamazoo 49006
Upjohn, Harold . . . . . .Upjohn Company, Kalamazoo 49006
VanArendonk, Gerald. .203 Upjohn Dr., Kalamazoo 49001
Van Den Brink, Paul. . . . . .507 Bronson Mdcl. Ctr., Kalamazoo 49006
VanderVelde, K. M. . .252 E. Lovell St., Kalamazoo 49006
VanHare, James J. . . . .3506 Lovers Lane, Kalamazoo 49001
Varley, Alan B. . . . .2146 Treehaven Dr., Kalamazoo 49001
Vecchio, Thomas J. (A) . .1423 W. South, Kalamazoo 49007
Verhage, Martin D. . .228 W. Cedar St., Kalamazoo 49007
Volderauer, John C. . .458 W. South St., Kalamazoo 49006
Walker, John S. . .Riker Laboratories, 19901 Nordhoff St., Northridge, Ca. 91324
Warnke, Robt. D. . . . . . .1634 Gull Road, Kalamazoo 49001
Weadon, Preston S. . . .252 E. Lovell St., Kalamazoo 49006
Webb, Joseph P. (A) Upjohn Company, Kalamazoo 49006
Wedeking, Fred L. (M) . . . . .Western Mich. Univ., Kalamazoo 49003
Williamson, Edwin M. . .252 E. Lovell St., Kalamazoo 49006
Wilson, Doyle E. . . . . .252 E. Lovell St., Kalamazoo 49006
Woodhams, William H. . .3125 W. Main, Kalamazoo 49007
Wu, Jack F. . . . . . . .810 E. Center Ave., Kalamazoo 49001
Yang, William G. . . . .3125 W. Main St., Kalamazoo 49007
Yaple, Edward L. . . . . . .1141 S. Rose St., Kalamazoo 49001
Youngs, Cyril A. (L) . . . . .416 So. Burdick St., Kalamazoo 49006
Zettelmaier, John L. . . . . .1631 Gull Rd., Kalamazoo 49001
Zolen, Margaret H. . . . . . .628 S. Park St., Kalamazoo 49007

KENT COUNTY MEDICAL SOCIETY (106)

Advani, Ram. .1840 Wealthy St. S.E., Grand Rapids 49506
Aitken, Geo. T. . .50 College Ave. S.E., Grand Rapids 49503
Albers, G. Donald . . . . .203 Paris Ave., S.E., Grand Rapids 49503
Aldridge, Chas. W., Jr. . . . . .153 Lafayette S.E., Grand Rapids 49503
Alfenito, Felix S., Jr. . . . . .515 Lakeside Dr. S.E., Grand Rapids 49506
Alger, George D. . . . . .2410 Gaynor Ave. N.W., Grand Rapids 49504
Allen, Ralph V. (L) . . . . .1669 Plainfield Ave. N.E., Grand Rapids 49505
Anderson, Jerry W. 245 State St. S.E., Grand Rapids 49502
Anderson, Karl A. (A) . . . . .2663 Reeds Lk. Blvd. S.E., Grand Rapids 49506
Andre, Harvey M. 500 Cherry St. S.E., Grand Rapids 49503
Armbrustmacher, V. W. (A) . . . .1840 Newark Ave. S.E., Grand Rapids 49507
Ashby, Robert N. . . . . .201 Lafayette Ave. S.E., Grand Rapids 49503
Avery, Noyes L., Jr. . . . . .515 Lakeside Dr. S.E., Grand Rapids 49506
Baker, Robt. J. . .6850 Division Ave. S., Grand Rapids 49508
Bakker, Durward J. . . . . .1033 Fulton St. W., Grand Rapids 49504
Balyeat, Gordon W. . . . . .150 Morningside Dr. S.E., Grand Rapids 49506
Barofsky, Gerald F. . . . . .808 Alger St. S.E., Grand Rapids 49507
Bartek, Gordon L. . .833 Lake Dr. S.E., Grand Rapids 49502
Basinger, Clair E. . . . . .1810 Wealthy St. S.E., Grand Rapids 49506
Baughman, Fred A., Jr. . . . . .1810 Wealthy St. S.E., Grand Rapids 49506
Baum, Wm. C. . . .153 Lafayette S.E., Grand Rapids 49503
Baxter, Wm. D. (A) . . . . .1125 Hoyt St. S.E., Grand Rapids 49507
Beard, Jeriel A. (A) . . . . .3900 Fuller Ave. N.E., Grand Rapids 49505
Beaton, James H. . .153 Lafayette S.E., Grand Rapids 49503

Beeman, Carl B. . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Beets, W. Clarence 124 Fulton St., E., Grand Rapids 49502
Bell, Chas. M. . . 50 College Ave. S.E., Grand Rapids 49503
Benisek, George J. . . . 305 Dogwood N.E., Ada 49301
Benjamin, Howard G. . . . 72 Sheldon Ave. S.E., Grand Rapids 49502
Bennett, Wm. D. (A) . . Pontiac State Hosp., Pontiac 48053
Benson, Roland R. 201 Lafayette S.E., Grand Rapids 49503
Bergsma, Stuart. . . . 6850 Division S., Grand Rapids 49508
Beukema, Marenus J. . . . 6850 S. Division Ave., Grand Rapids 49508
Bignall, C. Rexford. . . . 245 State Street S.E., Grand Rapids 49503
Birkbeck, Benjamin H. . . . 26 Sheldon Ave., S.E. Grand Rapids 49502
Blocksma, Ralph. . . 245 State St. S.E., Grand Rapids 49503
Boelkins, Richard C. . . . 125 Fountain St. N.E., Grand Rapids 49503
Boerman, Walter J. . . . 2410 Gaynor Ave. N.W., Grand Rapids 49504
Boersma, Donald. . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Boet, John T. . . 750 Fuller Ave. N.E., Grand Rapids 49503
Bonzelaar, Marvin. . . . 2740 Eastern Ave. S.E., Grand Rapids 49507
Booher, Craig E. . . . 1810 Wealthy St. S.E., Grand Rapids 49506
Botting, A. J. . . . . 2360 84th St. S.W., Byron Center 49315
Bowman, Harold E. . . . 201 Lafayette S.E., Grand Rapids 49503
Boyce, David C. . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Brace, F. C. . . . . 1498 Lake Dr. S.E., Grand Rapids 49506
Bratt, Harvey J. . . . 833 Lake Dr. S.E., Grand Rapids 49506
Braunschneider, Geo. E. . . . 2410 Gaynor Ave. N.W., Grand Rapids 49504
Brink, J. Russell 50 College Ave. S.E., Grand Rapids 49503
Bull, Frank L. . . . 72 E. Division, Sparta 49345
Burhans, John B. . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Burroughs, F. M., Jr. (A) 3307 Ottawa, Grandville 49418
Burton, Robert D. . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Burton, M. C. (A) . . . 3060 Cascade Road, S.E., Grand Rapids 49506
Butler, Wm. J. (A) . . . 6552 Shepherd Hills, Tucson, Az. 85710
Byrd, Mary L. . . . 700 Kent Hills Rd. N.E., Grand Rapids 49505
Callaway, Charles L. . . . 1330 Bradford St., N.E., Grand Rapids 49503
Campos, Manuel M. . . . 72 Sheldon Ave., S.E., Grand Rapids 49502
Capps, Samuel C. . . . 100 Michigan St. N.E., Grand Rapids 49503
Carpenter, L. C. 50 College Ave. S.E., Grand Rapids 49503
Cate, James R. (A) . . . 19 Goethals Dr., Ft. Leonard Wood, Mo. 65473
Caukin, Howard S. . . . 500 Cherry St. S.E., Grand Rapids 49503
Cayce, Wm. . . . . 245 State Street S.E., Grand Rapids 49502
Champion, John P. . . . 2060 Robinson Rd. S.E., Grand Rapids 49506
Chandler, Donald. . . . 60 Monroe Ave., N.W., Grand Rapids 49502
Chase, Robert J. 833 Lake Drive S.E., Grand Rapids 49506
Chatterton, J. Roger (A) . . . . . 936 Pinecrest Ave., S.E., Grand Rapids 49506
Chen, Mey En (A) . . . 518 Belvedere Dr. S.E., Grand Rapids 49506
Clahassey, Erwin G. . . . 50 College Ave. S.E., Grand Rapids 49503
Clark, James F. . . . 201 Lafayette Ave., S.E., Grand Rapids 49503
Clawson, Carroll K. . . . 445 Cherry St. S.E., Grand Rapids 49503
Claytor, Robt. W. . . . 1424 Madison Ave. S.E., Grand Rapids 49507
Clodfelder, R. Paul (M) . . . 5486 C Jamison, Ft. Knox, Ky. 40121
Corbus, Burton R. (L) . . . 500 Fulton St. E., Grand Rapids 49503
Crane, Harold D. . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Cremer, John A. . . . 911 Leonard St. N.W., Grand Rapids 49504
Crissman, Richard K. . . . 2747 Clyde Park S.W., Grand Rapids 49509
Dassel, Paul M. . . . . 2641 Boston S.E., Grand Rapids 49506
Davis, David B. (R) . . . . 266 Pettis Ave. N.E., Ada 49301
Davis, Thomas B. . . . 1810 Wealthy St. S.E., Grand Rapids 49506
Dawson, Walter D. . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Dean, Alfred (L) . . . Sagola 49881
DeBoer, Arthur F. . . . 2435 Eastern Ave. S.E., Grand Rapids 49507
DeBoer, Clarence J. . . 3011 Wilson S.W., Grandville 49418
DeBoer, Guy W. . . . 26 Sheldon Ave. S.E., Grand Rapids 49502
Deigert, Fredk. A. (A) . . . . . 3244 Eschol, Zion, Ill. 60099
DeJonge, Bud R. . . 909 Fulton St. E., Grand Rapids 49503
Delnay, Richard M. . . . 1908 Menominee Dr. S.E., Grand Rapids 49506
Dennison, H. Eugene (M) . . . 13 Maas Dr., Ft. Bragg, N.C. 28307
DePree, Isla G. (R) . . . Drummond Island 49726
DeVel, Leon (R) . . . 739 Plymouth Blvd. S.E., Grand Rapids 49506
Dewey, Kent A. . . 456 Cherry St. S.E., Grand Rapids 49503
Dice, Nanette. . . . 535 Greenwood Ave. S.E., Grand Rapids 49506
Dick, Mark W. . . . 146 Monroe Ave. N.W., Grand Rapids 49502
Dickason, Wayne L. (A) . . . 2501 Richards Dr. S.E., Grand Rapids 49506
Diskey, Donald G. 2015 Bridge N.W., Grand Rapids 49504
Dixon, Willis L. 26 Sheldon Ave. S.E., Grand Rapids 49502
Docter, Luebert 26 Sheldon Ave. S.E., Grand Rapids 49502
Doorenbos, Harvey E. (A) . . . Box 11, Muscat Oman, Se. Arabia
Doorn, Henry A. . . . . 2450 Lee S.W., Grand Rapids 49509
Doornbos, Fred A. . . 245 State St. S.E., Grand Rapids 49502
Dorain, Wallace B. . . . 1810 Wealthy St. S.E., Grand Rapids 49506
Doyle, John L. . . . . 2435 Eastern S.E., Grand Rapids 49507
Duffin, Wallace B. . . . 221 Michigan St., N.E., Grand Rapids 49503
Dye, Robert A. . . . . 124 Fulton St. E., Grand Rapids 49502
Dykman, Calvin J. . . . 515 Lakeside Dr. S.E., Grand Rapids 49506
Eary, L. Edmond, Jr. . . . . 222 Harper Drive, Sparta 49345
Eaton, Robert M. (A) . . . 709 Crestwood Dr., Waverly, Ohio 45690
Edholm, Curtis D. . . . 50 College Ave. S.E., Grand Rapids 49503
Eggleston, Robert L. . . . 1514 Wealthy S.E., Grand Rapids 49506
Eldersveld, Herman C. . . . 815 Alger St. S.E., Grand Rapids 49507
Ellis, Michael E. . . 242 Jefferson S.E., Grand Rapids 49502
Engels, John P. . . . 1840 Wealthy St. S.E., Grand Rapids 49506
Ericsson, Kermit C. (A) . . Box 2323, Addis Ababa, Ethopia
Farber, Chas. E. 50 College Ave. S.E., Grand Rapids 49503
Fatum, Paul J. . . 2054 Cambridge S.E., Grand Rapids 49506
Faust, Lawrence W. (L) . . . Morrison Lake Gardens, Saranac 48881
Feenstra, L. H. . . . 833 Lake Dr. S.E., Grand Rapids 49506
Fellows, Kenneth E. . . . 515 Lakeside S.E., Grand Rapids 49506
Ferguson, James A. . . . 72 Sheldon Ave. S.E., Grand Rapids 49502
Ferrand, Louis G. . . . . 8149 Northland Dr., Rockford 49341
Fierens, E. E. . . 456 Cherry St., S.E., Grand Rapids 49503
Fitts, Ralph L. . . 50 College Ave. S.E., Grand Rapids 49503
Fitzgerald, Erwin L. . . . 50 College Ave. S.E., Grand Rapids 49503
Flintoff, Wm. M. . . . 1632 Diamond Ave. N.E., Grand Rapids 49505

Flynn, J. Donald................515 Lakeside Dr. S.E., Grand Rapids 49506
Fochtman, Thos. W.........72 E. Division, Sparta 49345
Foshee, J. Clinton (L)..............Box 131, Ada 49301
Foxworthy, John P..................50 College Ave. S.E., Grand Rapids 49503
Frantz, Charles H...............1810 Wealthy St. S.E., Grand Rapids 49506
Fricke, David W. (A)..Peace Corps, c/o U. S. Embassy, Kabul, Afghanistan
Fuller, Edson H., Jr.............514 Medical Arts Bldg., Grand Rapids 49502
Fuller, Raymond E..............515 Lakeside Dr. S.E., Grand Rapids 49506
Fuller, Wm. J...515 Lakeside Dr. S.E., Grand Rapids 49506
Gamm, Kenneth E....................153 Lafayette S.E., Grand Rapids 49503
Gendler, Harvey M...269 Northland Dr., Rockford 49341
Gerard, Donald G.........311 E. Main St., Lowell 49331
Gibbs, E. Kent (A)..........2891 Northville Dr., N.E., Grand Rapids 49505
Gilbert, Ralph H.................26 Sheldon Ave., S.E., Grand Rapids 49502
Gillett, Fredk. S...................50 College Ave. S.E., Grand Rapids 49503
Girard, Scott B. (A)..............470 Tuttle Ave. N.E., Grand Rapids 49503
Glessner, James R., Jr...............1324 Lake Dr. S.E., Grand Rapids 49506
Goldberg, Salomea J.............515 Lakeside Dr. S.E., Grand Rapids 49506
Good, C. Robert..............2743 De Hoop St., S.W., Grand Rapids 49509
Graff, Russell G.................515 Lakeside Dr. S.E., Grand Rapids 49506
Grass, Edward J...833 Lake Dr. S.E., Grand Rapids 49506
Gray, Fred B.....456 Cherry St. S.E., Grand Rapids 49503
Greene, Perry W., Jr..................515 Lakeside S.E., Grand Rapids 49506
Grosenbaugh, Clare H.............1810 Wealthy St. S.E., Grand Rapids 49506
Gunn, James A....................1840 Wealthy St. S.E., Grand Rapids 49506
Gunning, Robt. E. Lee..........369 Greenwich Rd. N.E., Grand Rapids 49506
Haeck, William....245 State St. S.E., Grand Rapids 49503
Hagerman, David B. (L)........1551 Seminole Rd. S.E., Grand Rapids 49506
Hamp, Arthur K................515 Lakeside Dr. S.E., Grand Rapids 49506
Harmeling, Mark P...............500 Cherry St., S.E., Grand Rapids 49503
Harrison, Robert W.............1810 Wealthy St., S.E., Grand Rapids 49506
Hayes, Robert E...456 Cherry St. S.E., Grand Rapids 49503
Hayes, Thomas A. (A)................2604 Faber Ct., Falls Church, Va. 22046
Heaton, John R. 72 Sheldon Ave. S.E., Grand Rapids 49502
Heetderks, Dewey R. (L)........240 Edgehill Ave. S.E., Grand Rapids 49506
Heetderks, D. R., Jr...............26 Sheldon Ave. S.E., Grand Rapids 49502
Helder, Louis..1947 Hutchinson S.E., Grand Rapids 49506
Helmus, Christian..................203 Paris Ave. S.E., Grand Rapids 49503
Herrick, Ruth............908 E. Main St., Lowell 49331
Hesselschwerdt, D. W...............928 Princeton S.E., Grand Rapids 49506
Hill, A. Morgan..50 College Ave. S.E., Grand Rapids 49503
Hill, Jack W...6850 Division Ave. S., Grand Rapids 49508
Hodgkinson, C. P., II............26 Sheldon Ave. S.E., Grand Rapids 49502
Hoekstra, Andrew L........Mental Health Ctr., Montcalm Community, Sidney 48885
Hoekstra, Philip J...909 Fulton St. E., Grand Rapids 49503
Hoffs, Albertus J...............2607 Fredericks Dr. S.E., Grand Rapids 49506
Holkeboer, Henry D. (A)......1050 Spaulding Ave. S.E., Grand Rapids 49506
Hollander, Stephen................1451 Grandville Ave., Grand Rapids 49509
Holm, Robert S..................515 Lakeside Dr., S.E., Grand Rapids 49506
Hoogerhyde, Jack................26 Sheldon Ave. S.E., Grand Rapids 49502
Horning, David J.................26 Sheldon Ave. S.E.,
Hotchkiss, Brian L...............515 Lakeside Dr. S.E., Grand Rapids 49506
Grand Rapids 49502
Howie, Charles...833 Lake Dr., S.E., Grand Rapids 49506
Hoyt, Robt. L...................1810 Wealthy St. S.E., Grand Rapids 49506
Hudson, Harry C.................50 College Ave. S.E., Grand Rapids 49503
Hufford, A. Ray....455 Cherry S.E., Grand Rapids 49502
Humphrey, James C...............26 Sheldon Ave. S.E., Grand Rapids 49502
Hunter, Marilyn R........311 E. Main St., Lowell 49331
Hutchinson, F. A...245 State St. S.E., Grand Rapids 49502
Hydrick, Robt. H...1039 W. Fulton, Grand Rapids 49504
Ireland, Hoesa D...................750 Fuller Ave. N.E., Grand Rapids 49503
Irwin, James R...................26 Sheldon Ave. S.E., Grand Rapids 49502
Irwin, Jerry L...................26 Sheldon Ave. S.E., Grand Rapids 49502
Jack, Wm. W...1810 Wealthy St. S.E. Grand Rapids 49506
Jameson, Fred M...833 Lake Dr. S.E., Grand Rapids 49506
Jaracz, Walter J. (L).............634 Bridge St. N.W., Grand Rapids 49504
Jaracz, Walter J., Jr.............2410 Gaynor Ave. N.W., Grand Rapids 49504
Jarka, Robt. W...................50 College Ave. S.E., Grand Rapids 49503
Jarvis, Chas., Jr...............1520 Plainfield Ave. N.E., Grand Rapids 49505
Jensen, William B., Jr.................425 Cherry S.E,. Grand Rapids 49502
Jewell, Patrick F. (M).............5234 Mt. Alifan Dr., San Diego, Ca. 92111
Johns, Donald C...............655 Broadview St. S.E., Grand Rapids 49507
Johnsgard, Larry S. (A)................305 Tinker Dr., Ft. Worth, Tx. 76114
Johnston, Dan W.................2440 Beechwood S.E., Grand Rapids 49506
Johnston, Wm. L....................245 State St. S.E., Grand Rapids 49502
Jones, Edward A.................346 Wealthy St. S.E., Grand Rapids 49503
Jones, Haven E...................833 Lake Drive S.E., Grand Rapids 49506
Jui, John O. L..............4234 Lake Mich. Dr. N.W., Grand Rapids 49504
Kammeraad, L. A.................1810 Wealthy St. S.E., Grand Rapids 49506
Kaschel, Paul E.................1330 Bradford St. N.E., Grand Rapids 49503
Kelley, Donald E.................515 Lakeside Dr. S.E., Grand Rapids 49506
Kempers, David W...............50 College Ave. S.E., Grand Rapids 49503
Kempter, Albert H...................1200 Lake Dr. S.E., Grand Rapids 49506
Kessler, Dale L.................540 Belvedere Dr. S.E., Grand Rapids 49506
Ketcham, Donn W. (A)..................GPO Box 78, Chittagong, E. Pakistan
Kincaid, William E..............100 Michigan St. N.E., Grand Rapids 49503
Klein, Jacob E. (M)........RR 2 Box 30, Bangor 49013
Klein, Thomas....833 Lake Dr. S.E., Grand Rapids 49506
Klomparens, James T............1662 Morningside S.E., Grand Rapids 49506
Kniskern, Paul W................26 Sheldon Ave. S.E., Grand Rapids 49502
Kool, Bernard P....................445 Cherry St. S.E., Grand Rapids 49503
Korhonen, Bert J. (A)......2-2885 Ness Ave., St. James, Manitoba, Canada
Kraai, Harm (A)............8 Avn. Bn., APO N.Y. 09185

Krecke, Charles F...............201 Lafayette Ave. S.E., Grand Rapids 49503
Kreulen, Henry J.......................2452 Godwin S.E., Grand Rapids 49507
Krhovsky, Frank J..............153 Lafayette Ave. S.E., Grand Rapids 49503
Kruse, Wm. T., Jr. (A)..............3044 Hall St. S.E., Grand Rapids 49506
Kuiper, K. V...................2208 Madison Ave. S.E., Grand Rapids 49507
Laird, Robt. G...................26 Sheldon Ave. S.E., Grand Rapids 49502
Lalime, Ruth E. 52 Burton St., West, Grand Rapids 49507
Lamberts, Austin E..................909 Fulton St. E., Grand Rapids 49503
Lang, Ramon B...............1520 Plainfield Ave. N.E., Grand Rapids 49505
Leep, Jos. H...................1545 Diamond Ave. N.E., Grand Rapids 49505
Lentini, Jos. R.....303 Fulton St. E., Grand Rapids 49502
Levine, Robert S..................50 College Ave. S.E., Grand Rapids 49503
Lewis, Geo. H.......3011 Wilson S.W., Grandville 49418
Lieffers, Harry (L)..............26 Sheldon Ave. S.E., Grand Rapids 49502
Lincer, William T...................110 Fulton St. E., Grand Rapids 49502
List, Carl F.....833 Lake Dr. S.E., Grand Rapids 49506
Lobbes, Kenneth E..................425 Cherry St. S.E., Grand Rapids 49502
Logie, James W...............Ramona Medical Center, Grand Rapids 49506
Lovell, F. Raymer, Jr. (A)..............17179 Melrose, Southfield 48075
Lukens, Jack G...245 State St. S.E., Grand Rapids 49502
MacDonell, James A...............50 College Ave. S.E., Grand Rapids 49503
MacIntyre, Dugald S..............515 Lakeside Dr. S.E., Grand Rapids 49506
Maher, James T...............405 Medical Arts Bldg., Grand Rapids 49502
Mancewicz, Jerome F...........1156 Leonard St. N.W,. Grand Rapids 49504
Mann, Jos. D...100 Michigan St. N.E., Grand Rapids 49503
Marsh, John P. (L)................35 Bel Air Dr. N.E., Grand Rapids 49503
Marsh, Stephen K..6143 28th St. S.E., Grand Rapids 49506
Marshall, Robert B...............100 Michigan St. N.E., Grand Rapids 49503
Martinus, Martin................750 Fuller Ave. N.E., Grand Rapids 49503
Marvin, John A. (A)...............2439 Lake Dr. S.E., Grand Rapids 49506
Mason, Warren B.................50 College Ave. S.E., Grand Rapids 49503
Maternowski, C. J..............515 Lakeside Dr. S.E., Grand Rapids 49506
Mathis, Ralph E...245 State St., S.E., Grand Rapids 49502
Maycroft, T. C..................238 Bristol Ave. N.W., Grand Rapids 49504
Maynard, Mason S.................445 Cherry St. S.E., Grand Rapids 49503
Mays, James D. (A)............2602 Frederick Dr. S.E., Grand Rapids 49506
McCormick, John K..............221 Michigan St. N.E., Grand Rapids 49503
McDougal, Wm. J.................127 Fountain St. N.E., Grand Rapids 49503
McKay, Orval I...........311 E. Main St., Lowell 49331
McKinlay, Leland M. (R).........403 Dixie Dr. South, Howey in the Hills, Fla. 32737
McLain, Myrtle S...............221 Michigan St. N.E., Grand Rapids 49503
Meade, Richard H., Jr. (A)..........750 San Jose Drive, Grand Rapids 49506
Meester, Walter D. (A)........1840 Wealthy St., S.E., Grand Rapids 49506
Mehney, Gayle H...245 State St. S.E., Grand Rapids 49502
Meyer, Judith L.................1756 Newark Ave. S.E., Grand Rapids 49507
Millard, James A..................1553 Boston St. S.E., Grand Rapids 49507
Miller, J. D.....50 College Ave. S.E., Grand Rapids 49503
Miller, Theo. P...................833 Lake Drive S.E., Grand Rapids 49506
Moberg, Carl H...833 Lake Dr. S.E., Grand Rapids 49506
Moen, Cornetta G. (L)..............215 Paris Ave. S.E., Grand Rapids 49503
Moleski, Joseph V.................26 Sheldon Ave. S.E., Grand Rapids 49502
Moleski, Leo T...26 Sheldon Ave. S.E., Grand Rapids 49502
Moleski, Stanley L...35 Lyon St. N.W., Grand Rapids 49502
Moleski, Walter L. (A)..............40 Buckeye Lane, Willingboro, N. Y. 08046
Moll, Arthur M. (L).........146-156 Monroe Ave. N.W., Grand Rapids 49502
Mollmann, Arthur H. (L).........506 Mulford Dr. S.E., Grand Rapids 49507
Montgomery, John C.............1810 Wealthy St. S.E., Grand Rapids 49506
Moore, Douglas P...............515 Lakeside Dr. S.E., Grand Rapids 49506
Moore, Joseph S..............1520 Plainfield Ave. N.E., Grand Rapids 49505
Moorhead, E. L., II..............100 Michigan St. N.E., Grand Rapids 49503
Mouw, Dirk R..1854 S. Division Ave., Grand Rapids 49507
Mulder, G. Arthur................1414 Eastern Ave. S.E., Grand Rapids 49507
Muldoon, James P.................72 Sheldon Ave. S.E., Grand Rapids 49502
Murphy, Miles J. (M)..........153 Lafayette Ave. S.E., Grand Rapids 49503
Nahn, Charles E. (A) 36th Tac Hospital, APO N.Y. 09132
Nanzig, Reinard P...................153 Lafayette S.E., Grand Rapids 49503
Newton, John P...............1632 Diamond Ave. N.E., Grand Rapids 49505
Nickel, Kenneth C...............833 Lake Drive S.E., Grand Rapids 49506
Noordhoff, M. Samuel (A)....92 N. Chung Sham, Sec. 2, Taipei, Taiwan
Northouse, Peter B...............26 Sheldon Ave. S.E., Grand Rapids 49502
Notier, Victor A..................50 College Ave. S.E., Grand Rapids 49503
Nykamp, Paul W. (A)............1661 W. Hazelwood, Phoenix, Arizona 85015
Oates, Saml. M...245 State St. S.E., Grand Rapids 49502
O'Brien, James D...............1156 Leonard St. N.W., Grand Rapids 49504
O'Driscoll, Wm. G.................515 Lakeside Dr. S.E., Grand Rapids 49502
Orders, Richard L...............255 Washington S.E., Grand Rapids 49502
Ortwig, Ralph W. (A)..............120 N. Lang Ave., Pittsburgh, Pa. 15208
Overbeek, Ernest L.................26 Sheldon Ave. S.E., Grand Rapids 49502
Ozkan, Avni D...1444 Michigan N.E., Grand Rapids 49503
Paalman, Russell J...............26 Sheldon Ave. S.E., Grand Rapids 49502
Palaszek, Theresa R.................833 Lake Dr. S.E., Grand Rapids 49506
Passinault, Wm. J..............26 Sheldon Ave., S.E., Grand Rapids 49502
Pattullo, Marshall...............515 Lakeside Dr. S.E., Grand Rapids 49506
Payne, C. Allen (L)..................1840 Wealthy St., Grand Rapids 49506
Pedden, John R...445 Cherry St. S.E., Grand Rapids 49503
Peirce, John C.................201 Lafayette Ave. S.E., Grand Rapids 49503
Pilling, Warren C...833 Lake Dr. S.E., Grand Rapids 49506
Piskin, M. S...1077 Leonard St. N.E., Grand Rapids 49503
Plekker, Johannes D.................833 Lake Dr. S.E., Grand Rapids 49506
Pool, Lee R.......245 State St. S.E., Grand Rapids 49502
Porter, Howard P., Jr............2743 De Hoop St., S.W., Grand Rapids 49509

Posthuma, Albert E.................153 Lafayette S.E., Grand Rapids 49503
Postma, Edward Y...245 State St. S.E., Grand Rapids 49503
Postma, Howard F...............3860 Chicago Dr. S.W., Grandville 49418
Potchen, E. James (A) E. Mallinckrodt, Inst. of Radiology, 510 Kings Highway, St. Louis Mo. 63110
Pott, Abraham L.................1011 Fulton St. E., Grand Rapids 49503
Prothro, Winston B............1619 Walker St. N.W., Grand Rapids 49504
Puite, Robert H................515 Lakeside Dr. S.E., Grand Rapids 49506
Raiman, Robert J.................50 College Ave. S.E., Grand Rapids 49503
Ralph, L. Paul..............2547 Oakwood Drive S.E., Grand Rapids 49506
Rasmussen, Richard A.............Blodgett Med. Bldg., Grand Rapids 49501
Reardon, D. F...1168 Nixon N.W., Grand Rapids 49504
Reus, Wm. F. (L)..................24 Burton St. S.E., Grand Rapids 49507
Reus, Wm. F., Jr.............153 Lafayette Ave. S.E., Grand Rapids 49503
Riekse, James M................2740 Eastern Ave. S.E., Grand Rapids 49507
Rienstra, John C..................833 Lake Drive S.E., Grand Rapids 49506
Riley, Paul M. (A)..................3713 Jackstadt St., San Pedro, Calif. 90731
Ringenberg, J. C..................50 College Ave. S.E., Grand Rapids 49503
Robb, Chas. S...445 Cherry St. S.E., Grand Rapids 49503
Robbert, John H.......4075 Prairie St., Grandville 49418
Robson, Larry J. (A)................U. S. Naval Hosp., Corpus Christi, Tx. 78419
Rodgers, Wm. L...2865 Lake Dr. S.E., Grand Rapids 49506
Roelofs, Charles W.............3000 Monroe Ave. N.W., Grand Rapids 49505
Rooks, Wendell H.................1339 Plainfield N.E., Grand Rapids 49505
Roosenberg, William............975 Union Bank Bldg., Grand Rapids 49502
Rosenzweig, Leonard.............515 Lakeside Dr. S.E., Grand Rapids 49506
Roth, Emil M. (A)......454 147th Ave., Caledonia 49316
Rottschafer, O. W..............50 College Ave., S.E., Grand Rapids 49503
Rupke, John A..................221 Michigan St. N.E., Grand Rapids 49503
Rupp, Theo. J...50 College Ave. S.E., Grand Rapids 49503
Ryan, John A...153 Lafayette S.E., Grand Rapids 49503
Ryskamp, James J., Jr. (A)............801 Shoreline Dr., Portsmouth, Va. 23703
Santinga, John T. (A)................Severence Hosp., Int. P.O. Box 1010, Seoul, Korea
Schaubel, Howard J................124 Fulton St. E., Grand Rapids 49502
Schek, Donald C.................2749 Clyde Park S.W., Grand Rapids 49508
Schermerhorn, L. J. (R)............2317 Vine Hill Rd., Santa Cruz, Calif. 95062
Schlosser, Ralph J..................456 Cherry St. S.E., Grand Rapids 49503
Schneider, Geo. R...............1810 Wealthy St. S.E., Grand Rapids 49506
Schnoor, Elmer W. (L).........844 Iroquois Drive S.E., Grand Rapids 49506
Schnute, Louise F...146 Monroe N.W., Grand Rapids 49502
Schroeder, Alan F. (M).............6259 Potomac St., San Diego, Calif. 92114
Schwaderer, Thos. G................500 Cherry St. S.E., Grand Rapids 49503
Scott, Wm. B...26 Sheldon Ave. S.E., Grand Rapids 49502
Scrimgeour, Alison W. (A)........1226 Ottillia St. S.E., Grand Rapids 49507
Sculley, Raymond E..............12 Burton St. S.E., Grand Rapids 49507
Seime, Reuben I. (A)...........835 Plymouth Rd. S.E., Grand Rapids 49506
Sentkeresty, J. A.................515 Lakeside Dr. S.E., Grand Rapids 49506
Setterstrom, Charles A...............734 Alger St. S.E., Grand Rapids 49507
Sevensma, Elisha S. (L)...........1077 Leonard N.E., Grand Rapids 49503
Sevensma, Eugene S..............124 Fulton St. East, Grand Rapids 49502
Sharda, Martin..................2435 Eastern Ave. S.E., Grand Rapids 49507
Sharp, Robert B...833 Lake Dr. S.E., Grand Rapids 49506
Shultz, Garth (A)...........346 Woodmere Ave., S.E., Grand Rapids 49506
Sidell, Richard H..............515 Lakeside Dr. S.E., Grand Rapids 49506
Siebers, Bernard H. (A)........Box 1258, Lansing, 48904
Siegel, Alan E..................1085 Leonard St. N.E., Grand Rapids 49503
Simpson, William D.............2777 Nipawin Ct. N.E., Grand Rapids 49505
Sluyter, John S..750 Fuller Ave. N.E., Grand Rapids 49503
Smith, Dean B...4236 Kalamazoo S.E., Grand Rapids 49508
Smith, John H. 1840 Wealthy St. S.E., Grand Rapids 49506
Smith, Robt. B. 26 Sheldon Ave. S.E., Grand Rapids 49502
Smith, R. Earle (L)........R#2, c/o A. P. Shugart, Sr., Lockney, Texas 79241
Snearly, Roland G.............201 Lafayette Ave. S.E., Grand Rapids 49503
Snider, John D................1827 Argentina Dr. S.E., Grand Rapids 49506
Snyder, Clarence A. (A)....Cibagora, Cyangugu Mission Hosp., B.P. 31 Rwanda, Africa
Southwick, C. H.................515 Lakeside Dr. S.E., Grand Rapids 49506
Southwick, G. Howard (L)............515 Lakeside S.E., Grand Rapids 49506
Sprague, Wm. E.................933 Leonard St. N.W., Grand Rapids 49504
Steffensen, W. H.................1810 Wealthy St. S.E., Grand Rapids 49506
Stonehouse, Garnet G. (R)......408 Medical Arts Bldg., Grand Rapids 49502
Stoneman, Fernley....3011 Wilson S.W., Grandville 49418
Stover, Virgil E.................545 Lakeside Dr. S.E., Grand Rapids 49506
Strong, LeRoy E.................515 Lakeside Dr. S.E., Grand Rapids 49506
Stuart, Gerhardus J. (L)............1140 Keystone Ave., River Forest, Il. 60305
Sugg, Cullen E. (L)............3175 Cascade Rd. S.E., Grand Rapids 49506
Sugiyama, Tetsuo..............26 Sheldon Avenue S.E., Grand Rapids 49502
Sun, Keh Ming..St. Marys Hosp. Lab., Grand Rapids 49503
Swan, Jerome W..................26 Sheldon Ave. S.E., Grand Rapids 49502
Swanson, Alfred B..............1810 Wealthy St. S.E., Grand Rapids 49506
Swenson, Harold C. 124 Fulton St. E., Grand Rapids 49502
Talbott, Timothy M. (A)........1542 Michigan St. N.E., Grand Rapids 49503
Taylor, Joseph L.................1033 Fulton St. West, Grand Rapids 49504
TenHave, John (L)............3515 Briggs Blvd. N.E., Grand Rapids 49505
TerKeurst, Donald H.............2740 Eastern Ave. S.E., Grand Rapids 49507
Tesseine, Arthur J..................1328 Madison S.E., Grand Rapids 49507
Teusink, James H...................Cedar Springs 49319
Theodore, Paul G............1520 Plainfield Ave. N.E., Grand Rapids 49505
Thompson, Athol B. (L).........1857 Golden Rain Rd., Walnut Creek, Ca. 94529
Thompson, Edward C...........153 Lafayette Ave. S.E., Grand Rapids 49503
Thompson, Frank D...........2008 El Dorado Dr. S.E., East Grand Rapids 49506
Tiffany, Jos. C.................502 Medical Arts Bldg., Grand Rapids 49501
Tomatis, Luis A...456 Cherry St. S.E., Grand Rapids 49503

Torgerson, Wm. R.............Ramona Medical Center, Grand Rapids 49506
Townsend, Jack H...............515 Lakeside Dr. S.E., Grand Rapids 49506
Troske, Robt. L.......534 Dogwood Dr. N.E., Ada 49301
Truog, Clarence P...110 Fulton St. E., Grand Rapids 49502
Turcotte, V. J., Jr...............515 Lakeside Dr. S.E., Grand Rapids 49506
Vaandrager, Vernon D..............245 State St. S.E., Grand Rapids 49502
Valdmanis, F.....2120 Lake Dr. S.E., Grand Rapids 49506
Van Bree, Raymond S................812 Rosalie N.W., Grand Rapids 49504
Van Dam, Forrest R.............1810 Wealthy St. S.E., Grand Rapids 49506
Vanden Berg, A. R. 833 Lake Dr. S.E., Grand Rapids 49506
Vandenberg, Wm...124 Fulton St. E., Grand Rapids 49502
Vanden Berg, Wm. O..............50 College Ave. S.E., Grand Rapids 49503
Vander Kolk, K. J...............2740 Eastern Ave. S.E., Grand Rapids 49507
Vander Meer, Raymond..........26 Sheldon Ave., S.E., Grand Rapids 49502
Vandermolen, John..124 Fulton St. E., Grand Rapids 49502
Vander Ploeg, R. A...............26 Sheldon Ave. S.E., Grand Rapids 49502
Vander Ploeg, Wm. H...............833 Lake Dr. S.E., Grand Rapids 49506
Van Der Veer, Corwin G.............245 State St. S.E., Grand Rapids 49503
Van Dommelen, G. M................245 State St. S.E., Grand Rapids 49502
Van Duine, Henry J.................153 Lafayette S.E., Grand Rapids 49503
Van Dyke, Harold E.............1108 Leonard St. N.E., Grand Rapids 49503
Van Etten, Donald D. (A)..Box 1, Bahrain, Arabian Gulf
Van Goor, Kornelius..............26 Sheldon Ave. S.E., Grand Rapids 49502
Van Nuis, Cornelis..................245 State St., S.E., Grand Rapids 49502
Van Otteren, G. F...................245 State St. S.E., Grand Rapids 49502
Van Portfliet, Paul..245 State St. S.E., Grand Rapids 49502
VanSolkema, Andrew A...............953 E. Fulton St., Grand Rapids 49503
Van't Hof, Albert.................50 College Ave. S.E., Grand Rapids 49503
Van Vliet, Peter D...............100 Michigan St. N.E., Grand Rapids 49503
Van Woerkom, Danl..............933 Leonard St. N.W., Grand Rapids 49504
Van Zwalenburg, B. R...........2116 Coronado Dr. S.E., Grand Rapids 49506
Vasu, C. Mark..833 Lake Drive S.E., Grand Rapids 49506
Veldman, Harold E. (L)..............26 Sheldon Ave., Grand Rapids 49502
Veltman, Jay H.......3946 G 30th St., Grandville 49418
Venema, Jay R...............540 Overbrook Lane S.E., Grand Rapids 49507
Ver Lee, Jimmie J. (A)................Galmi Hospital, Galmi Via Madaoua, Niger Republic, West Africa
Ver Meulen, John (L)..........2501 Central Ave. S.W., Grand Rapids 49509
Ver Meulen, Peter (A)..............105 Baynton N.E., Grand Rapids 49503
Verwys, A. L. Hubert................815 Alger St. S.E., Grand Rapids 49507
Vining, Keats K., Jr..............515 Lakeside Dr. S.E., Grand Rapids 49506
Vis, William R. (L)..............26 Sheldon Ave. S.E., Grand Rapids 49502
Visscher, H. C. 515 Lakeside Dr. S.E., Grand Rapids 49506
Visscher, Robert D.............515 Lakeside Drive S.E., Grand Rapids 49506
Visser, Earl R...............530 Overbrook Lane S.E., Grand Rapids 49507
Vogel, Anton..................1204 Madison Ave. S.E., Grand Rapids 49507
Volkel, James S...................833 Lake Drive S.E., Grand Rapids 49506
Voss, John A...................2410 Gaynor Ave. N.W., Grand Rapids 49504
Vroon, John....50 College Ave. S.E., Grand Rapids 49503
Vyn, Jay D. (L) 7119 Driftwood S.E., Grand Rapids 49506
Wahby, Elmer F.................100 Michigan St. N.E., Grand Rapids 49503
Walma, Daniel................26 Sheldon Avenue S.E., Grand Rapids 49502
Wassink, Roger N................26 Sheldon Ave. S.E., Grand Rapids 49502
Waterman, Donald F.............515 Lakeside Dr. S.E., Grand Rapids 49506
Watkins, James K.................26 Sheldon Ave. S.E., Grand Rapids 49502
Webb, Clarence F. 833 Lake Dr. S.E., Grand Rapids 49503
Webber, Jerome E.................50 College Ave. S.E., Grand Rapids 49503
Weeber, Thomas A...3011 Wilson S.W., Grandville 49418
Wehrenberg, R. A. (A)...........Pleasure Bay, Apt. 5, Long Branch, N.J. 07740
Weller, Keith E.................1200 Lake Drive S.E., Grand Rapids 49506
Wendt, Vernon E..................937 Fulton St. W., Grand Rapids 49504
Westendorp, Floyd...............6850 Division Ave. S., Grand Rapids 49508
Westerhoff, Robert J.................808 Alger St. S.E., Grand Rapids 49507
Whinery, Jos. F. 50 College Ave. S.E., Grand Rapids 49503
Whitehouse, John D...........1201 Colorado Ave. S.E. Grand Rapids 49506
Whittenberger, R. N.................245 State St. S.E., Grand Rapids 49502
Wiese, John L...50 College Ave. S.E., Grand Rapids 49503
Wilcox, Rex G. (A)..........1045 Keneberry Way S.E., Grand Rapids 49506
Wilderom, Morris...............1619 Walker St. N.W., Grand Rapids 49504
Wilkes, John B...............1328 Madison Ave. S.E., Grand Rapids 49507
Wilkinson, C. A.................2030 Leonard St. N.W., Grand Rapids 49504
Williams, John R...833 Lake Dr. S.E., Grand Rapids 49506
Wilson, John R. 1033 Fulton St. West, Grand Rapids 49503
Wilson, Robert J...1011 Fulton St. E., Grand Rapids 49503
Winfield, Emery D. (L)..............457 Burton S.E., Grand Rapids 49507
Winter, Garrett E.............1967 Godfrey Ave. S.W., Grand Rapids 49509
Wright, Thos B. (A)..........2614 Plainfield Ave. N.E., Grand Rapids 49505
Wurz, John F..................201 Norwood Ave. S.E., Grand Rapids 49506
Wyngaarden, Martin K..............245 State St. S.E., Grand Rapids 49503
Yared, Jerome A...651 Cherry St. S.E., Grand Rapids 49506
Yost, William G., Jr...............50 College Ave. S.E., Grand Rapids 49503
Young, Donald G...............100 Michigan St. N.E., Grand Rapids 49503
Zadvinskis, Z.....833 Lake Dr. S.E., Grand Rapids 49506
Zimmerman, Wm. G..............26 Sheldon Ave. S.E., Grand Rapids 49502
Zwemer, Rodger J..............1810 Wealthy St. S.E., Grand Rapids 49506

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M....Lapeer State Home, Lapeer 48446
Berker, Isak O.............South Street, Davison 48423
Bishop, G. Clare.........................Almont 48003
Boruch, Leon R...........834 Liberty St., Lapeer 48446
Conaway, Chas. E........1257 N. Main St., Lapeer 48446
Dorland, Clarke...........221 Lincoln St., Lapeer 48446
Doty, James R...............315 Clay St., Lapeer 48446
Greavu, Cornell, Jr.................North Branch 48461

Grunawalt, Robert E. (A) 821 Madison St., Lapeer 48446
Haney, M. Bennet.....409 E. St. Clair St., Almont 48003
Heitsch, Wm. C.........3257 Davison Rd., Lapeer 48446
House, Clifford............1750 Grey Rd., Lapeer 48446
Kiehler, E. G., II........3257 Davison Rd., Lapeer 48446
Kim, S. J................4462 Thorntree Dr., Flint 48506
Kocur, Lubomira...............Drawer A, Lapeer 48446
Lebedovych, Emil............Drwr. A, Lapeer S. Home, Lapeer 48446
Lebedovych, Ksenia.........Drawer A, Lapeer S. Home, Lapeer 48446
Leith, Dorothy L.........240 Main St., Imlay City 48444
Lopez, Leonardo V. (A)....295 W. Huron, Pontiac 48053
Lynk, Stanley M..........4589 Lippincott, Lapeer 48446
Smith, Ellen (A)...................400 White Rd., R. 1, Columbiaville 48421
Smith, Glenn L.....6552 Imlay City Rd., Imlay City 48444
Ucer, Erol (A).......2835 W. Genesee St., Lapeer 48446
Zemmer, H. R...............N. Main St., Lapeer 48446
Zolliker, Carl R. (R)......3646 Slattery Rd., Lum 48452

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O.........................Hudson 49247
Allen, Russell A.......415 W. Maumee St., Adrian 49221
Armovit, Herminio........236 S. Fourth St., Onsted 49265
Bachman, Joseph F.............602 E. Pottawatamie St., Tecumseh 49286
Balice, F. W.............128 E. Butler St., Adrian 49221
Baylon, Leonardo.........231 N. Main St., Adrian 49221
Benz, Carl A.............308 N. Broad St., Adrian 49221
Berghuis, John.........225 Riverside Ave., Adrian 49221
Blanchard, Lowell E.....................Hudson 49247
Blanden, Merwin R...................Tecumseh 49286
Boyd, James W.......4510 Southgate Lane, Adrian 49221
Burch, Larry T...........10 Cairns St., Tecumseh 49286
Coak, Richard D..............602 E. Pottawatamie St., Tecumseh 49286
Conner, Edward D..........3 Scott Court, Adrian 49221
Cook, Carlton L....603 E. Pottawatamie, Tecumseh 49286
Cooper, James H..........308 N. Broad St., Adrian 49221
Diccion, R. A...........................Morenci 49256
Dickman, Harry M...........104 Oak St., Hudson 49247
Dustin, Richard E.....103 W. Brown St., Tecumseh 49286
Eddy, Howard R. C..............Mill Rd., Adrian 49221
Feeney, James L..................Mill St., Adrian 49221
Galliani, M............4410 Evergreen Dr., Adrian 49221
Gamble, Kenneth...................R. 3, Hudson 49247
Gascoigne, Richard H. (M)..........693 Stockford Dr., Adrian 49221
Gilkey, William C.....693 Stockford Drive, Adrian 49221
Gilmartin, Richard................Mill St., Adrian 49221
Greiner, Robert A........Professional Bldg., Adrian 49221
Hamilton, John.................Mill St., Adrian 49221
Hamilton, Thomas........113 W. Front St., Adrian 49221
Hammersley, Gordon.....1361 Oregon Rd., Adrian 49221
Harrison, Robt. E.........418 W. Adrian, Blissfield 49228
Heffron, Chas H...........231 N. Main St., Adrian 49221
Heffron, C. Harold (L)....231 N. Main St., Adrian 49221
Heffron, Howard H........231 N. Main St., Adrian 49221
Helzerman, Ralph F...112 S. Ottawa St., Tecumseh 49286
Hewes, Wm. H..................Mill Rd., Adrian 49221
Hunt, Philip.....................Mill St., Adrian 49221
Locke, Francis A.............755 High St., Adrian 49221
Marsh, Roland G. B. (L)..............1938 Spruce St., Boulder, Co. 80302
Marshall, Mary L....1389 W. Maple Ave., Adrian 49221
Miller, P. Lynford..............GMC Fisher Body Div., 5550 Occidental Hwy., Tecumseh 49286
Ocamb, Harold D...600 E. Pottawatamie, Tecumseh 49286
Parker, Donald A...........Bixby Hospital, Adrian 49221
Patmos, Bernard........127 E. Maumee St., Adrian 49221
Phelan, Alvin J...............10 Cairns, Tecumseh 49286
Purfield, Wm. P.....................Manchester 48158
Quadros, Everton.....................Blissfield 49228
Raabe, Elmer C........................Morenci 49256
Richey, Bert R.....765 Manitou Rd., Manitou Beach 49253
Sarapo, Donato F.................Mill St., Adrian 49221
Shannon, Gordon (A).................Blissfield 49228
Skufis, Eleanor P.........201 Orchard Rd., Adrian 49221
Skufis, Xenophon.........123 E. Chestnut, Adrian 49221
Stewart, Landis C............750 High St., Adrian 49221
Taylor, Richard L.......Emma Bixby Hosp., Adrian 49221
Van Dusen, Chad A. (L).......R.F.D. 5, Blissfield 49228
Wentz, Patricia.............760 Riverside, Adrian 49221
White, Robert B.............945 Riverside, Adrian 49221
Whitehouse, Keith H....................Morenci 49256
Wilson, Geo. C.................Box 224, Clinton 49236
Wolf, Marvin B..........689 Stockford Dr., Adrian 49221
Wynn, Geo. H...........1115 W. Maumee, Adrian 49221

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A..........116 N. Michigan, Howell 48843
Clarke, Niles A......116 W. Grand River, Brighton 48116
Damstra, Donald L. 12893 E. Grand River, Brighton 48116
Duffy, Ray M. (L)........P.O. Box 106, Pinckney 48169
Granowski, Karol..........McPherson Comm. Hlth. Ctr., Howell 48843
Harebottle, Norman H.............25 W. University Dr., Tempe, Arizona 85281
Hauer, R. Fred......................Fowlerville 48836
Hendren, Jesse J. (R)..................Fowlerville 48836
Higby, Thomas F....................Fowlerville 48836
Hill, Harold C.......116 N. Michigan Ave., Howell 48843
Hoffman, Stanley L.......1200 Byron Road, Howell 48843
May, Louis E...............City Route 4, Howell 48843
Perry, Florence J. C...............17640 San Rose Ave., Lathrup Village 48075
Phillips, R. W.........................Hamburg 48139
Polack, Robt. T.........1225 Lakeside Dr., Howell 48843
Schenden, A. J. (R)......2753 Page St., Ann Arbor 48104
Schmitt, Phillip E......515 So. Tompkins, Howell 48843
Sheng, Luke H. C....111 W. Grand River, Brighton 48116
Stuber, Roscoe V..........1200 Byron Rd., Howell 48843
Walker, Enos G......4485 Cordley Lake, Lakeland 48143
Wang, Stella K. C.......111 Grand River, Brighton 48116
Woodworth, Edwin S......1200 Byron Rd., Howell 48843

LUCE COUNTY MEDICAL SOCIETY (122)

Barstow, Donald K....................Engadine 49827
Dale, Edward C...............Box 9, Newberry 49868
Eadie, Gordon A.,........East Upper Pen. Health Dept., Newberry 49868
Gibson, Robert D...804 Newberry Ave., Newberry 49868
Gibson, Robt. E. L., Jr...207 W. John St., Newberry 49868
Grennan, Lawrence E. (A)........1344 Northlawn N.E., Grand Rapids 49505
Hicks, R. P.............210 W. John St., Newberry 49868
Kearney, Martin J.............118 Brewer Dr., Apt. 14A, Battle Creek 49015
Keizer, B. G.......Newberry State Hosp., Newberry 49868
Margoles, Milton..Newberry State Hosp., Newberry 49868
Purmort, Wm. R., Jr.............Newberry State Hosp., Newberry 49868
Thompson, Thos. W. (L)...........Route 2, Box 691M, Traverse City 49684

MACOMB COUNTY MEDICAL SOCIETY (126)

Alejos, Juan E..........276 43 Schoenherr, Warren 48093
Alexander, James H...25815 Harper, St. Clair Shores 48081
Alvarez, Mercedes..11686 Eleven Mile Rd., Warren 48093
Ambrose, Robt. H. 18801 E. Ten Mile Rd., Roseville 48066
Arellano, Miguel A......21500 Mound Rd., Warren 48091
Audretsch, F. E...........355 Lincoln, Grosse Pte. 48230
Averbuch, Fred, Maj., MC (A)......USAF Hosp., APO, San Francisco, Ca. 96323
Barker, John G.....8050 Warren Blvd., Center Line 48015
Beecher, Alvin J.........21501 Kelly, East Detroit 48021
Bigley, Bernard........35992 Gratiot, Mt. Clemens 48043
Biluk, Frank J..........GM Tech. Center, Warren 48092
Bishai, Yousef B. 11477 E. Twelve Mile Rd., Warren 48093
Blain, Donald G......198 S. Gratiot, Mt. Clemens 48043
Bond, Franklyn F...4861 E. Nine Mile Rd., Warren 48091
Bower, Allen B. (L)....................Armada 48005
Brown, Leland C....21536 Parkway, St. Clair Shores 48082
Bryce, James W..24735 Van Dyke Ave., Center Line 48015
Bulcourf, Carlos J......31170 Hoover Rd., Warren 48093
Carruthers, W. B.......198 S. Gratiot, Mt. Clemens 48043
Chabator, George........294 Benjamin St., Romeo 48065
Charbeneau, Harold P...229 S. Gratiot, Mt. Clemens 48043
Charbonier, Luis M...........11868 E. Eleven Mile Rd., Warren 48089
Clay, Joel W.......263 S. Gratiot Ave., Mt. Clemens 48043
Cohen, Alan.......12500 Twelve Mile Rd., Warren 48093
Cohen, Alberto.....25705 Stonycroft Dr., Southfield 48075
Colah, Sorab A.................708 Monitor Leader Bl., Mt. Clemens 48043
Collon, David (A) D.D.S.................Romeo 48065
Corbett, John.........225 S. Gratiot, Mt. Clemens 48043
Cosio, Jose.......St. Joseph Hospital, Mt. Clemens 48043
Croman, Jos. M., Jr. (R)...............131 Market St., Mt. Clemens 48043
Curatolo, Victor......67 Cass Ave., Mount Clemens 48043
Danan, Bernardo M..11477 E. 12 Mile Rd., Warren 48089
Darian, H. B........11528 E. 12 Mile Rd., Warren 48093
Deal, Harold R..........23700 Van Dyke, Warren 48089
Deocampo, E.......20720 Maxine, St. Clair Shores 48080
Deocampo, Nestor D.............11477 Twelve Mile Rd., Warren 48093
Depaulis, Dario C........22770 Kelly, East Detroit 48021
Dilone, Polibio A.....493 W. Grand Blvd., Detroit 48216
Dionne, Paul........8216 E. 12 Mile Rd., Warren 48093
Dudzinski, Edmund J...............424 Washington St., New Baltimore 48047
Ebner, Charles M..................25520 Little Mack, St. Clair Shores 48081
Ekelman, Seymour B.....14 Belleview, Mt. Clemens 48043
Ellias, Elmer P..........23700 Van Dyke, Warren 48089
Engels, John A..........69311 N. Main, Richmond 48062
Erkfitz, Arthur W.....RR# 2 Crabapple Rd., c/o R. E. Smith, Roswell, Ga. 30075
Eyl, Thomas B..........66704 Van Dyke, Romeo 48065
Fagelman, Jerry S...........27841 Adler, Warren 48093
Finn, James Wm...............46056 Cass, Utica 48087
French, Lawrence W.....................25815 Harper, St. Clair Shores 48081
Friedman, Herbert F.............13087 Eleven Mile Rd., Warren 48093
Fulgenzi, Andrew A............17301 E. Eight Mile Rd., East Detroit 48021
Gerbasi, Francis...................81 Lochmoor Blvd., Grosse Pte. Shs. 48236
Gesser, Charles................17800 E. Eight Mile Rd., Harper Woods 48236
Goldin, Morris I.........6902 Chicago Rd., Warren 48092
Goldman, Bernard J.................243 S. Gratiot Ave., Mt. Clemens 48043
Gonzalez, C. G.........20 Parkview, St. Joseph Hospital, Mt. Clemens 48043
Haas, Michael.......................20867 Mack Ave., Grosse Pte. Wds. 48236
Hahne, Otto H...8425 E. Twelve Mile Rd., Warren 48093
Hartmann, Waldemar B.................1416 S. Gratiot, Mount Clemens 48043
Hiller, Herbert M...............13500 E. Twelve Mile Rd., Warren 48093
Hirzel, Leon S..............33080 Garfield, Fraser 48026
Horvath, Julius........18847 Rosetta, East Detroit 48021
Hoski, Joseph A...8425 E. Twelve Mile Rd., Warren 48093
Hranchook, Michael......30001 Van Dyke, Warren 48093
Hull, Frank J....728 Canterbury, Grosse Pte. Woods 48236
Iacobelli, Claudio M..................22745 Kelly Rd., East Detroit 48021
Iglesias, Ernesto R..............608 Monitor Leader Bl., Mt. Clemens 48043
Isaacs, Eli M..........14230 Greenbriar, Oak Park 48237
Isbey, Edward K...........28494 Hoover, Warren 48093
Jacobs, Manuel......23700 Van Dyke Ave., Warren 48089
Jewell, James H...Roseville Theatre Bldg., Roseville 48066
Kane, John P..........67 Cass Ave., Mount Clemens 48043
Kane, Peter V.....230 North Ave., Mount Clemens 48043
Kane, Wm. J. (L)..171 North Avenue, Mt. Clemens 48043
Katzman, Harold L...13500 E. 12 Mile Rd., Warren 48093
Key, Robin S..........28495 Hoover Rd., Warren 48093
Kingsley, Joyce W., Jr...............18801 Ten Mile Rd., Roseville 48066
Kipp, Paul R...........14 Belleview, Mt. Clemens 48043
Kirtland, Wm. B., Jr.............18801 E. Ten Mile Rd., Roseville 48066
Klein, Alfred A..........23700 Van Dyke, Warren 48089
Knoblauch, K. H...8425 Twelve Mile Rd. E., Warren 48093
Kokeny, Wm. J.....23700 Van Dyke Ave., Warren 48093
Kommel, Richard M....................26510 Dundee, Huntington Wds. 48070
Krieger, Bruce..............15250 Park, Oak Park 48237
Krieger, Harvey A...13500 12 Mile Rd. E., Warren 48093
Kripke, Morton J............11255 Hall Rd., Utica 48087
Kroon, Joseph D...............656 Wellington Crescent, Mt. Clemens 48043
Kuntzman, Carl E....134 University Dr., Rochester 48063
Kurtz, Hyman..........16712 Timberview, Fraser 48026
Kypros, George P..................25520 Little Mack, St. Clair Shores 48081
Lapp, Charles.............7817 McClellan, Utica 48087
Lee, Lawrence E. 8425 E. Twelve Mile Rd., Warren 48093
Lee, Thomas E......13403 E. 13 Mile Rd., Warren 48093
Levi, Charles....8262 E. Twelve Mile Rd., Warren 48093
Licata, Samuel A.....21349 Kelly Rd., East Detroit 48021
Llaneza, Onofre B...................21420 Harper Ave., St. Clair Shores 48080
Loo, Rodolfo V.............1664 Witherbee, Troy 48084
Lopez, Gerald L....25660 Lexington Lane, Roseville 48066
Lubera, Richard J...................25520 Little Mack, St. Clair Shores 48081
Lublin, Ann.............5224 St. Antoine, Detroit 48202
Maguire, Andrew J.........45569 Van Dyke, Utica 48087
Marcuz, Edo V.............11255 Hall Rd., Utica 48087
Marinelli, Ralph..8252 E. Twelve Mile Rd., Warren 48093
Mark, Hansi.........8236 E. 12 Mile Rd., Warren 48093
Martin, Wm. L.............117 S. Main St., Romeo 48065
Mattes, Max W..........18456 Wildemere, Detroit 48221
Matthews, C., Jr.........14 Belleview, Mt. Clemens 48043
Maxim, Edward S.......225 S. Gratiot, Mt. Clemens 48043
Mayer, Mary L......715 S. Rogers, Apt. 19, Mason 48854
McGinty, John D......243 S. Gratiot, Mt. Clemens 48043
McMorrow, Kathryn........28526 Hoover, Warren 48093
Merametdjian, Krikor....22841 Van Dyke, Warren 48089
Merritt, Jule J...36640 S. Gratiot Ave., Mt. Clemens 48043
Messmer, Harold O..........7817 McClellan, Utica 48087
Meyers, Sidney S...........28477 Hoover, Warren 48093
Miller, Sidney S.........28477 Hoover Rd., Warren 48093
Moore, Geo. F. (L)....69434 N. Forest, Richmond 48062
Morris, Gerald W.......14 Belleview, Mt. Clemens 48043
Mulligan, Philip T...............612 Monitor Leader Bl., Mount Clemens 48043
Nance, Marion E..........P.O. Box 157, Weidman 48893
Nutting, Helen M.................22631 Greater Mack, St. Clair Shores 48080
Ornstein, Chas.......21701 Kelly Rd., East Detroit 48021
O'Shee, Vincent..8216 E. Twelve Mile Rd., Warren 48093
Oughtred, Orville....26401 Harper, St. Clair Shores 48081
Pacho, Marc..........25786 Cambridge, Roseville 48066
Paris, Delmo A....18801 E. Ten Mile Rd., Roseville 48066
Parmelee, N. H.......50551 Van Dyke Ave., Utica 48087
Parnagian, Leo........14 Belleview, Mt. Clemens 48043
Perez, Florence........25786 Cambridge, Roseville 48066

Porretta, Anthony C..................2112 Venier Rd., Grosse Pte. Wds. 48236
Pugliesi, Frank J.....20927 Kelly Rd., East Detroit 48021
Ragheb, Moufid..............705 N. Valley Chase Rd., Bloomfield Hills 48013
Rakotz, Gerald....13087 Eleven Mile Rd., Warren 48093
Ramos, Antonio E.......29846 Schoenherr, Warren 48093
Reitzel, Rufus H...................199 S. Gratiot Ave., Mount Clemens 48043
Revere, Jos. O...192 S. Gratiot Ave., Mount Clemens 48043
Riddle, Charles B...............620 Eastland Prof. Bld., Harper Woods 48236
Rinkenberger, E. A.................243 S. Gratiot Ave., Mt. Clemens 48043
Rivkin, Jos...........14 Belleview, Mount Clemens 48043
Rooney, Robert..........23700 Van Dyke, Warren 48089
Roth, Geo. E.........19136 Mendota Ave., Detroit 48221
Rothman, Arthur M.................22422 Gratiot Ave., East Detroit 48021
Rourke, Ronald E...................21503 Harper Ave., St. Clair Shores 48080
Rousseau, Daniel L..............Monitor Leader Bldg., Mt. Clemens 48043
Rush, Wm. E.............St. Johns Hosp., Detroit 48236
Russell, Paul..........198 S. Gratiot, Mt. Clemens 48043
Ryan, Jack.........23700 Van Dyke Ave., Warren 48089
Ryan, Thomas E.....39310 Gary Ave., Mt. Clemens 48043
Salot, Russell F.......67 Cass Ave., Mount Clemens 48043
Sarnacki, Carl J...8425 Twelve Mile Rd. E., Warren 48093
Scher, Jos. N........130 Cass Ave., Mount Clemens 48043
Scher, Sydney......132 Cass Ave., Mount Clemens 48043
Schmunk, Robert F...136 Cass Avenue, Mt. Clemens 48043
Setter, Thomas J.....16214 Chatham Drive, Fraser 48026
Shawky, Yehya A. 8425 E. Twelve Mile Rd., Warren 48093
Shaya, Ezra S..............31170 Hoover, Warren 48093
Sheppard, Lawrence F............23700 Van Dyke Ave., Warren 48089
Sherbin, Herbert D.............12500 Twelve Mile Rd., Warren 48093
Sherman, Gerald......12500 12 Mile Rd., Warren 48093
Siegfried, Edward G..............229 S. Gratiot Ave., Mt. Clemens 48043
Silverman, M. P.......28477 Hoover Road, Warren 48093
Simmons, Milton F...........12500 E. Twelve Mile Rd., Warren 48093
Sims, Wm. N........229 S. Gratiot, Mount Clemens 48043
Singer, Nelson.....22100 Gratiot Ave., East Detroit 48021
Stanton, James........225 S. Gratiot, Mt. Clemens 48043
Starbird, Wm. A.........8216 E. 12 Mile, Warren 48093
Starkman, Morris..........28477 Hoover, Warren 48093
Steele, George H.......229 S. Gratiot, Mt. Clemens 48043
Steinberger, Eugene.....23700 Van Dyke, Warren 48089
Stepka, Joseph E..........50551 Van Dyke, Utica 48087
Stief, Kirwin..218 N. Christine Circle, Mt. Clemens 48043
Stone, Julius..........198 S. Gratiot, Mt. Clemens 48043
Stoyka, Charles.....21503 Harper, St. Clair Shores 48080
Stroude, Donald E. (A) D.D.S.....8425 Twelve Mile Rd., Warren 48093
Stryker, Oscar D. (L)..............38422 Hidden Lane, Mt. Clemens 48043
Sturm, Fredk. A.........76 Lochmoor, Grosse Pte. 48236
Suksta, Adolph W......23350 Gratiot, East Detroit 48021
Suzuki, M...............23700 Van Dyke, Warren 48089
Thompson, Alfred A. 126 Cass Ave., Mount Clemens 48043
Tinkey, L. Leo.....8306 Twelve Mile Rd., Warren 48093
Transue, David (M)..13403 E. 13 Mile Rd., Warren 48093
Tucker, Kenneth F.......23700 Van Dyke, Warren 48089
Urbancic, William......22048 Gratiot, East Detroit 48021
Watts, Fredric.........27440 Hoover Rd., Warren 48093
Weinberger, K. A...27643 Schoenherr Rd., Warren 48093
Weiss, Jack I.......23700 Van Dyke Ave., Warren 48089
Whitley, Alec....21707 Erben Dr., St. Clair Shores 48081
Wilde, Maurice M...........5930 Chicago, Warren 48092
Wilson, Norman R. 225 S. Gratiot Ave., Mt. Clemens 48043
Witus, Carl..........21349 Kelly Rd., East Detroit 48021
Wolf, Ervin......Roseville Theatre Bldg., Roseville 48066
Wyte, Wm. C.....263 S. Gratiot Ave., Mt. Clemens 48043
Yamasaki, Ken..........23700 Van Dyke, Warren 48089
Zager, Bernard S...4133 Mattos Dr., Fremont, Calif. 94536
Zavela, Dan......679 N. Renaud, Grosse Pte. Wds. 48236
Zink, Robert A.....................25815 Harper Ave., St. Clair Shores 48081
Zook, Mr. Gilbert E. (A)...............253 S. Gratiot, Mt. Clemens 48043
Zotovas, Alex..........23700 Van Dyke, Warren 48089

MANISTEE COUNTY MEDICAL SOCIETY (130)

Custer, Harry R........723 Park Ave., Charlevoix 49720
Futterer, LeRoy A.....Forest Clinic Bldg., Manistee 49660
Garneau, Robt. R.....Forest Clinic Bldg., Manistee 49660
Hansen, Ernest C...........326 First St., Manistee 49660
Kellawan, Karl K..........Forest Clinic, Manistee 49660
Konopa, John F............57 Poplar St., Manistee 49660
Miller, Ernest B............326 First St., Manistee 49660
Paterson, Roger............310 9th St., Manistee 49660
Ramsdell, Homer A. (L)...398 River St., Manistee 49660
Rosenow, K. G........Forest Clinic Bldg., Manistee 49660
Schwing, Donald N...Forest Clinic Bldg., Manistee 49660
Wild, David A............84 Cypress St., Manistee 49660

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Acocks, James R...Morgan Hgts. Sanat., Marquette 49855
Amolsch, Arthur L. (L)..1008 Bluff St., Marquette 49855
Beaghler, R. L..................St. Lukes Hosp., Path., Marquette 49855
Bennett, Matthew C..............1414 W. Fair Avenue, Marquette 49855
Berry, Robt. F....1414 W. Fair Avenue, Marquette 49855
Bertucci, Jos. P.........114 S. First St., Ishpeming 49849
Bolitho, Thos. B...1414 W. Fair Avenue, Marquette 49855
Brish, Adam........1414 W. Fair Ave., Marquette 49855
Bujard, Robert S.....1414 W. Fair Ave., Marquette 49855
Carefoot, Rankin L...............1414 W. Fair Avenue, Marquette 49855
Casler, Wilbur L. (L)..131 E. Ridge St., Marquette 49855
Celori, Luciano.........427 W. College, Marquette 49855
Conley, Donal T...1414 W. Fair Avenue, Marquette 49855
Cooperstock, Moses..1414 W. Fair Ave., Marquette 49855
Corcoran, Wm. A. (L)..............200 S. Main Street, Ishpeming 49849
Elzinga, Donald R...1414 W. Fair Ave., Marquette 49855
Elzinga, Eugene R...............1414 W. Fair Avenue, Marquette 49855
Emani, Firooz......1414 W. Fair Ave., Marquette 49855
English, John W...1414 W. Fair Avenue, Marquette 49855
Flores, R................613 Lake St., Marquette 49855
Green, Southgate J.......................Gwinn 49843
Hopkins, William F...............1414 W. Fair Avenue, Marquette 49855
Hornbogen, Danl. P...............1414 W. Fair Avenue, Marquette 49855
Howe, Lloyd W. (L)..............Savings Bank Bldg., Marquette 49855
Huffman, Elston R...............1414 W. Fair Avenue, Marquette 49855
Humphrey, William C...829 Croix Street, Negaunee 49866
Jaedecke, Robt. G...........829 Croix, Negaunee 49866
Kane, Elizabeth D. (R)..............418 W. Magnetic, Marquette 49855
Koenig, Harry......540 E. Division St., Ishpeming 49849
Kronschnabel, E. F..............1414 W. Fair Avenue, Marquette 49855
Kublin, John C.......1414 W. Fair Ave., Marquette 49855
Lambert, Warren C....347 E. Ridge St., Marquette 49855
Lexmond, M. J........524 Mather Ave., Ishpeming 49849
Lincke, E. T......1414 W. Fair Avenue, Marquette 49855

Lyons, Barbara E...Student Hlth. Ctr., Northern Mich. Univ., Marquette 49855
Lyons, James W.........803 N. 3rd St., Marquette 49855
Matthews, Norman L.............N. Mich. Child Clinic, Marquette 49855
Morris, John C......401 29th Street, Oakland, Calif. 94609
Mudge, Thomas J...1414 W. Fair Avenue, Marquette 49855
Mudge, Wm. A. (L).....108 Ridge St., Negaunee 49866
Narotzky, Archie S.......Miracle Circle, Ishpeming 49849
Newell, Wilson G........101 S. Fourth, Ishpeming 49849
Niemi, Osmo (R)................Box 151, Gwinn 49843
Oldham, Earle S....427 W. College Ave., Marquette 49855
Olson, Walter R.........Sand Point Rd., Munising 49862
Pearson, Wallace G..............1414 W. Fair Avenue, Marquette 49855
Pillote, Florence A.....26 Lakeview Dr., Marquette 49855
Pillote, John F.....1414 W. Fair Avenue, Marquette 49855
Potter, Richard..........P.O. Box 790, Marquette 49855
Rosenbaum, Louis......524 Mather St., Ishpeming 49849
Sabin, Fredk. C...1414 W. Fair Avenue, Marquette 49855
Schmidt, Merle C. (A)................111 W. 39th St., Vancouver, Wa. 98660
Schroeder, W. Gene (M)...............524 Mather St., Ishpeming 49849
Schweinsberg, Sara K. D. (A)....507 Bemis Rd. R.F.D., Saline 48176
Tobin, James F., Jr.........724 Elliott, Ishpeming 49849
Van Riper, Paul (L)..................Champion 49814
Wall, David R.......Aitamont & Fisher, Marquette 49855
Williams, Reginald G....524 Mather St., Ishpeming 49849
Wilson, George M., Jr.............1414 W. Fair Avenue, Marquette 49855
Wright, Kenneth C...............1414 W. Fair Avenue, Marquette 49855

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr.......101 N. Main, Scottville 49454
Boon, A. Floyd..........203 N. Ferry, Ludington 49431
Carney, John R........202 N. Park St., Ludington 49431
Carney, Ruth V. C....202 N. Park Ave., Ludington 49431
Castellani, R. J...........P.O. Box 349, Ludington 49431
Clark, Harry L. (L)..............510 N. Lakeshore Dr., Ludington 49431
Craymer, Austin..........420 N. Rath, Ludington 49431
Ewing, R. L.........600 Tinkham Ave., Ludington 49431
Hoffman, Howard B. 7418 Golfwood Rd., Ludington 49431
Irick, Robert..........Memorial Hosp., Ludington 49431
Kleinschmidt, Gladys J...........401 E. Ludington Ave., Ludington 49431
Martin, Wm. S..........107 Ludington, Ludington 49431
Mayer, Gerry..............806 Russell, Ludington 49431
Morrow, Wm. J.......2511 Elm Ave., Evanston, Il. 60201
Ostrander, Robt. A............5000 E. Grand Rd., #5, Tucson, Az. 85716
Paukstis, Chas. A.......111 E. Court St., Ludington 49431
Ramsey, John........119 N. James St., Ludington 49431
Sutter, Wm. F.........220 S. James St., Ludington 49431
Waun, James.........506 E. Ludington, Ludington 49431

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Asplund, Charles M.......213 Elm St., Big Rapids 49307
Bruggema, Jacob.................Main St., Evart 49631
Davis, Roy A......Ferris State College, Big Rapids 49307
Haldeman, Jack......1014 S. State St., Big Rapids 49307
Hickox, Leland A.....1014 S. State St., Big Rapids 49307
Kilmer, Paul B..........102 W. Upton, Reed City 49677
Kowaleski, Edward H....................Remus 49340
Lincoln, Norman V.......108 E. Upton, Reed City 49677
Merlo, Frank A.....206 S. Michigan St., Big Rapids 49307
Moon, Wm. W.................Box 175, Baldwin 49304
Nelson, Lorenzo R............R. F. D. 1, Baldwin 49304
Phelps, Leland B.....111 S. Chestnut St., Reed City 49677
Price, Leonard....Ferris State College, Big Rapids 49307
Pusczak, George B........213 Elm St., Big Rapids 49307
Tyson, James L...1014 South State St., Big Rapids 49307
Van Auken, Edward W...229 S. Warren, Big Rapids 49307
Veenschoten, Girard.......380 South St., Baldwin 49304
Walters, James E.....1014 S. State St., Big Rapids 49307
White, John A.....121 S. Michigan St., Big Rapids 49307

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O..........531 1st St., Menominee 49858
Brukardt, Herman R......534 First St., Menominee 49858
Dewane, Francis J......413 10th Ave., Menominee 49858
Glickman, L. Grant.....958 First St., Menominee 49858
Gonty, Arthur..St. Joseph Lloyd Hosp., Menominee 49858
Heidenreich, John R.....................Daggett 49821
Hopson, George H. (A)............19186 Santa Barbara, Detroit 48221
Hopson, Patricia C. (A)...........19186 Santa Barbara, Detroit 48221
Jones, Wm. S. (L)....1146 Tenth Ave., Menominee 49858
Jones, Wm. S., Jr......1146 10th Ave., Menominee 49858
Kerwell, Karm C. (L)....P. O. Box 17, Stephenson 49887
Strefling, John (O)..................Stephenson 49884
Towey, John W. (L)..................1717 Orchid Lane Middleton, Wi. 53562

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Baker, Ophelia P...936 W. Houghton, West Branch 48661
Baker, Thomas A...936 W. Houghton, West Branch 48661
Blaha, Vernon B......................Grayling 48738
Boehm, John D. (R)..State Hospital, Traverse City 49684
Bontrager, W. E..........................Mio 48647
Christensen, D. E......N. Mich. TB San., Gaylord 49735
Christensen, Willis L.....617 North Court, Gaylord 49735
Clippert, C. G. (R)...308 Michigan Ave., Grayling 49738
Coulter, Keith D. (R)................8019 Garlot Drive, Annandale, Va. 22003
Crandell, Clare H. (R).............West Branch 48661
Dosch, Paul..........................Grayling 49738
Forney, Fred A. (L)
Godfroy, Bernard...................Roscommon 48653
Hayes, Louis F.............7330 Deep Run Lane #1523, Birmingham 48020
Henig, Benj. E.......................Grayling 49738
Howarth, Thos. W......................Gladwin 48624
Jardine, Hugh M...................West Branch 48661
Kieler, George E....................Roscommon 48653
Koltay, Marta Szego............Tolfree Memorial Hosp., West Branch 48661
Koltay, Oscar P.................Tolfree Memorial Hosp., West Branch 48661
Libke, Robert S........................Gaylord 49735
Oppy, Charles L....................Roscommon 48653
Potvin, Clifford D.....308 Michigan Ave., Grayling 49738
Rusak, R. D...........................Gladwin 48624
Schaiberger, Geo. L................West Branch 48661
Stealy, Stanley A. (L)................Grayling 49738
Timreck, Harold A......................Gladwin 48624
Tongco, Rustico C.......617 N. Court St., Gaylord 49735
Van Oosten, Howard E...117 Burgess, West Branch 48661
Wiegerink, L. T....................West Branch 48661

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R)......4622 Concord Ct., Midland 48640
Basel, Arthur R...........901 Crescent, Midland 48640
Benjamin, Mac B............307 Cass St., Sanford 48657
Bennett, Donald R......3902 Applewood, Midland 48640
Bernier, Jos. A...........218 E. Railway, Sanford 48657
Blackhurst, J. F......2715 Ashman Street, Midland 48640
Blackhurst, Robt. T........233 E. Larkin, Midland 48640
Bowsher, Robt. E.......4005 Orchard Dr., Midland 48640
Bridge, Robt. G............2715 Ashman, Midland 48640
Bulmer, Dan J..........2707 Ashman St., Midland 48640
Bush, Raymond C........808 W. Sugnet, Midland 48640
Buskirk, Maurice D.......110 W. Sugnet, Midland 48640
Cline, J. Daniel..........920 W. Sugnet, Midland 48640
Devlin, James A.............115 Jerome, Midland 48640
Ducommun, Dale J.........Dow Chemical Co. Box 469, Midland 48640
Ellis, Ruth.................2510 Ashman, Midland 48640
Esparza, Higinio S.
Fields, Dozier N., Jr.....515 W. Main St., Midland 48640
Gay, Harold H. (R)...Dow Chemical Co., Midland 48640
Goethe, Roy M.......222 N. Saginaw Rd., Midland 48640
Gordon, Harold L.....Dow Chemical Co., Midland 48640
Grant, Robert...........2931 Manor Dr., Midland 48640
Grewe, Norman C........501 E. Pine St., Midland 48640
Gunderson, Edw. P....2000 Dilloway Dr., Midland 48640
Haberstroh, Colleen.....3710 Applewood, Midland 48640
Harrigan, William E.......2706 Louanna, Midland 48640
Heffernan, D. D..........402 Dartmouth, Midland 48640
Himmelsbach, Wm. A........5411 Sturgeon Crk. Pkwy., Midland 48640
Holder, Benj. B.............Dow Chem. Co. Med. Dept., Midland 48640
Holland, Frederick R.....1801 Rapanos, Midland 48640
Howe, Irvin M...........110 W. Sugnet, Midland 48640
Howell, Richard H.........2707 Ashman, Midland 48640
Ittner, Martin J.......217 N. Saginaw Rd., Midland 48640
Johns, David B.............Dow Chemical Co. Box 469, Midland 48640
Kiyak, Yahya..............206 Graham, Midland 48640
Kramer, Chas. G...Box 469, Dow Chemical, Midland 48640
Kwast, Harold A...........2715 Ashman, Midland 48640
Linsenmann, Karl W.....2604 Manor Dr., Midland 48640
Marks, V. A..............2706 Louanna, Midland 48640
Maynard, Wm. A..........208 N. Fourth, Coleman 48618
Meisel, Edward H., Jr......Masonic Bldg., Midland 48640
Mesaros, Michael P...222 N. Saginaw Rd., Midland 48640
Moench, G. Fredk.........147 Center St., Sanford 48657
O'Hona, Bernard A.......110 W. Sugnet, Midland 48640
Pike, Melvin H............224 E. Larkin, Midland 48640
Pollock, Robert.........2707 Ashman St., Midland 48640
Poznak, Leonard A.....4005 Orchard Dr., Midland 48640
Randolph, Stephen H. 201 E. Ellsworth St., Midland 48640
Redmon, William B..........115 Jerome, Midland 48640
Reif, James........222 N. Saginaw Rd., Midland 48640
Sanislow, Charles A.....2707 Ashman St., Midland 48640
Scharf, Forrest........4005 Orchard Dr., Midland 48640
Scharnweber, H. C....Dow Chemical Co., Midland 48640
Schoff, Charles A..........2706 Louanna, Midland 48640
Shriner, John W......222 N. Saginaw Rd., Midland 48640
Smith, Donald S., Jr. (M)..2715 Ashman, Midland 48640
Smock, Sidney N.........2006 Norwood, Midland 48640
Towsley, Wilbur D.......515 W. Main St., Midland 48640
Ulmer, George............4005 Orchard, Midland 48640
Van Sickle, Robert L...............222 N. Saginaw Rd., Midland 48640
Westphal, Harry O.........910 Eastlawn, Midland 48640
Willison, Chas. H.......122 Townsend St., Midland 48640
Yobst, G. James...........2719 Ashman, Midland 48640

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D. (L)..2 W. Noble Ave., Monroe 48161
Barrett, C. D., Sr. (L) 2133 Hollywood Dr., Monroe 48161
Bartolo, Anthony H........757 N. Monroe, Monroe 48161
Black, Charles E.......721 N. Macomb St., Monroe 48161
Blakey, Leonard C. (L) 745 N. Monroe St., Monroe 48161
Bond, Wm. W............222 N. Monroe, Monroe 48161
Burroughs, J. J.........745 N. Monroe St., Monroe 48161
Cigany, Zoltan B.......................Carleton 48117
Clark, Bruce........8308 Lewis Ave., Temperance 48182
Costa, Frank..........21941 Woodruff, Rockwood 48173
Diehl, George Z..........721 N. Macomb, Monroe 48161
Diehl, Joy O. S.........15463 S. Monroe, Monroe 48161
Douglas, Dale W............124 Cole Rd., Monroe 48161
Dranginis, E. J.........Memorial Hospital, Monroe 48161
Ewing, Robt. T. (L)....130 Maple Blvd., Monroe 48161
Flanders, John P.......753 N. Monroe St., Monroe 48161
Frary, Reginald A..........505 Strasburg, Monroe 48161
Freud, John W.......1262 N. Macomb St., Monroe 48161
Hensel, Hilda M............12 E. 4th St., Monroe 48161
Hnatczuk, Nikolas..8078 Summerfield, Lambertville 48144
Ivanichek, Francis....610 N. Macomb St., Monroe 48161
Johnson, A. Esther.....751 N. Monroe St., Monroe 48161
Kelso, S. Newton, Jr.........116 Cole Rd., Monroe 48161
King, John R.............12 East 4th St., Monroe 48161
Laboe, Edward W. (R)....424 Hollywood, Monroe 48161
Lammers, Gerald P..........................Ida 48140
Libres, Joseph........721 N. Macomb St., Monroe 48161
Liedel, Warren J...........136 Cole Rd., Monroe 48161
Long, Edgar C.........1310 N. Macomb St., Monroe 48161
Lusher, William T....8308 Lewis Ave., Temperance 48182
McGeoch, Reginald W. (L)........718 N. Macomb St., Monroe 48161
McMillin, John H. (L)....423 E. Elm St., Monroe 48161
Mehregan, Amir H.......12 E. Fourth St., Monroe 48161
Meier, Walter A............134 Cole Rd., Monroe 48161
Middleton, W. S......219 W. Front Street, Monroe 48161
Ozdaglar, Mehmet N......721 N. Macomb, Monroe 48161
Pena, Emilio.............424 Monroe St., Dundee 48131
Pinkus, Hermann K. B.......12 E. 4th St., Monroe 48161
Reisig, Albert H.........1 S. Monroe St., Monroe 48161
Sisman, Bernard............130 Cole Rd., Monroe 48161
Streicher, Robt. G......729 N. Monroe St., Monroe 48161
Tomlinson, Ledyard H.....8718 Main St., Newport 48166
Wagar, Spencer H......31 Washington St., Monroe 48161
Weeks, Vernon L.........749 N. Monroe, Monroe 48161
Wilkins, Rolland W.........118 Cole Rd., Monroe 48161
Williams, Robt. J. (L)..31 Washington St., Monroe 48161

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Aardema, Austin A.......1470 Peck St., Muskegon 49441
Allen, Richard T...768 W. Broadway, Muskegon Hts. 49444
Alt, William J......Medical Arts Center, Muskegon 49440
Amos, David A..307 Medical Arts Bldg., Muskegon 49440
Annessa, G. W.....Medical Arts Center, Muskegon 49440
Askam, Ralph F.....Medical Arts Center, Muskegon 49440
Atkinson, Annie L. (A)...........R. 1, Montague 49437
August, Ralph V......................72 E. Broadway, Muskegon Heights 49444
Barnard, Helen S. (R)...........1382 E. Airport Rd., Muskegon 49441
Barnes, James W...102 Professional Bldg., Montague 49437
Barnett, James M. (M)...........2892 Baylis Dr. North, Ann Arbor 48104
Benedict, Arthur L., Jr.............22 W. Southern Ave., Muskegon 49441
Bloom, Robt. E.....Medical Arts Center, Muskegon 49440
Bolthouse, Robt. E...2101 Peck St., Muskegon Hts. 49444

Bond, Wm. H..........1282 Arthur St., Muskegon 49442
Boyd, DeVere R..........1735 Peck St., Muskegon 49441
Boyd, Jack L. (A).......1735 Peck St., Muskegon 49441
Bradshaw, Park S...Medical Arts Center, Muskegon 49440
Bultema, James H........1470 Peck St., Muskegon 49441
Busard, J. Max...........1200 Ransom, Muskegon 49442
Busard, Thos. R.....Medical Arts Center, Muskegon 49440
Carlson, Mr. James C. (A) 2060 Belmont, Muskegon 49441
Chapin, Wm. S. (A)..................2125 Maffett St., Muskegon Heights 49444
Chiasson, Antonio....4056 Nob Hill Dr., Muskegon 49441
Christophersen, J. W...............1276 Lake Shore Dr., Muskegon 49444
Clapp, Henry W...............202 Westgate Med. Twr., Muskegon 49441
Clifford, James D. (A)......452 Maple, Plymouth 48170
Closz, Harold F. (L)..1727 Jefferson St., Muskegon 49441
Cornell, Homer E...303 Medical Arts Ctr., Muskegon 49440
Crawford, John W., Jr.....1470 Peck St., Muskegon 49441
Cronick, Anne B.....435 Whitehall Rd., Muskegon 49445
Dart, Dorothy O. (A)..............428 W. Franklin St., Salisbury, N.C. 28144
Das, Kshitish.........506 Liberty Life Bldg., Muskegon
Dasler, Adolph F.........1507 Peck St., Muskegon 49441
De Leeuw, Henry....4090 Highgate Rd., Muskegon 49441
DeYoung, Roland W...3800 Monteview, Muskegon 49441
Diskin, Frank.....1324 Marquette Ave., Muskegon 49442
Ellis, Nicholas J...1891 Lake Shore Dr., Muskegon 49444
Engstrom, Albert D......117 W. Colby, Whitehall 49461
Farmer, John C.....Medical Arts Center, Muskegon 49440
Fillingham, Enid (R)....1034 Giles Rd., Muskegon 49445
Fles, Robt. J.............1715 Peck St., Muskegon 49441
Folsom, John D..........1706 Peck St., Muskegon 49441
Frandsen, Philip H.......1470 Peck St., Muskegon 49441
Fry, Phillip E. (A)..............2774 Patricia, Apt. 10, North Muskegon 49445
Fugate, E. M...206 Westgate Med. Twr., Muskegon 49441
Gaikema, Everett W. (R)................605 First St., North Muskegon 49445
Gamble, Robert N...............1310 Wisconsin Ave., Grand Haven 49417
Garber, Frank W., Jr.........1732 Peck, Muskegon 49441
Garber, Frank W. (L)..............235 Monroe Avenue, Muskegon 49441
Garrison, Robt. E., Jr..............210 Med. Arts Bldg., Muskegon 49440
Giese, Douglas H..............305 Westgate Med. Twr., Muskegon 49441
Gillard, James L.........1642 Peck St., Muskegon 49441
Goltz, Martha H. (L)..................Montague 49437
Grasman, Erwin.........3068 Wittkop, Muskegon 49440
Griffith, Robt. M...................966 W. Broadway, Muskegon Hgts. 49441
Hack, Donald W....Medical Arts Center, Muskegon 49440
Hanley, Wm. J.......315 W. Clay Ave., Muskegon 49440
Harris, W. Richard........852 Winslow, Muskegon 49441
Harryman, James E.....1200 Ransom St., Muskegon 49442
Hartwell, Shattuck W.................Northshore Hosp., North Muskegon 49445
Harvey, John G. Klemm (R)............Mercy Hospital, Muskegon
Heeres, Dale W.....1135 Hampden Rd., Muskegon 49441
Heneveld, John (R)..............Brasstown, N.C. 28902
Heneveld, Robt. G........1470 Peck St., Muskegon 49441
Hennessy, Mary E. (A) 1200 Ransom St., Muskegon 49442
Herald, Osbie J...............208 Westgate Mdcl. Twr., Muskegon 49441
Holly, Leland E. (L)..889 N. Second St., Muskegon 49440
Holly, Leland E., II..889 N. Second St., Muskegon 49440
Holm, Leo H.....212 Medical Arts Ctr., Muskegon 49440
Hornbeck, Wm. J......1200 Ransom St., Muskegon 49442
Howard, W. Leonard..635 Franklin, N. Muskegon 49445
Huntley, Richard A.............1704 W. Sherman Blvd., Muskegon 49441
Jesson, Robt. M........1200 Ransom St., Muskegon 49442
Johnston, E. H.......889 N. Second St., Muskegon 49440
Joistad, Arthur H., Jr...889 N. Second St., Muskegon 49440
Kane, Thos. J. (M)................2086 Leimert Blvd., Oakland, Ca. 94602

Kay, Cecelia S...........1533 Peck St., Muskegon 49441
Keilen, Marie (L).....Occidental Hotel, Muskegon 49443
Kelso, Charles T...15575 Oak Drive, Spring Lake 49456
Kerr, Howard J.........3054 Henry St., Muskegon 49444
Kislov, Richard...................1810 Ruddiman Ave., North Muskegon 49445
Kleaveland, Ingram J...1670 Peck Street, Muskegon 49441
Krenz, Marlin P...............Hackley Union Bk. Bldg., Muskegon 49443
Lange, Eugene W. (R)........680 Wauwatosa Rd., R 2, Cedarburg, Wi. 53012
Lauretti, Emil J.....Medical Arts Center, Muskegon 49440
Lauretti, L. A..........936 Second St., Muskegon 49440
Laurin, Vilda S. (L) Medical Arts Center, Muskegon 49440
Le Fevre, Geo. L., Jr. (R)................726 Lake Dr., North Muskegon 49445
Le Fevre, Wm. M. (L) 315 W. Clay Ave., Muskegon 49440
Lemmen, Lloyd J.........1724 Peck St., Muskegon 49441
Leonard, Mr. A. T. (A).............435 Whitehall Rd., Muskegon 49445
Loder, Leonel L...289 W. Western Ave., Muskegon 49440
Lowry, Robt. A. (A)..300 Hopi Place, Boulder, Co. 80302
Maire, Lewis E..........1633 Peck St., Muskegon 49441
Mandeville, C. B. (L) 5311 N. Bristol, Tacoma, Wa. 98407
Maples, Douglas E.............2612 Riverview, Apt. 11, N. Muskegon 49445
Marrs, Jack Winton....Med. Arts Bldg., Muskegon 49440
McNair, John N.........936 Second St., Muskegon 49440
Medema, Paul E.......1017 Sanford St., Muskegon 49440
Meengs, Marvin B........1725 Peck St., Muskegon 49441
Miller, Phillip L..........1755 Peck St., Muskegon 49441
Mulder, Lambertus..Medical Arts Center, Muskegon 49440
Oden, C. L. A. (L)..Medical Arts Center, Muskegon 49440
Oslund, Richard R.....889 N. Second St., Muskegon 49440
Packer, Robert C........4065 Stamford, Muskegon 49441
Parsons, Frank W..............206 Westgate Med. Twr., Muskegon 49441
Paterson, Lester C.........1643 Peck St., Muskegon 49441
Peterson, Wm. F......1094 Jefferson St., Muskegon 49440
Pettinga, Frank L.........1470 Peck St., Muskegon 49441
Risk, Robt. D..........1160 Ransom St., Muskegon 49442
Sanden, Howard V........1643 Peck St., Muskegon 49441
Scholle, Norbert W.............204 Westgate Med. Twr., Muskegon 49441
Shebesta, Emil M...Medical Arts Center, Muskegon 49440
Smith, Robert E....Medical Arts Center, Muskegon 49440
Steffee, William P. (A)................442 Valhalla Ct., Rochester, Minn. 55901
Stone, Thomas E...1900 Crestwood Dr., Muskegon 49441
Stratton, Donald P.......889 Second St., Muskegon 49440
Stubbart, F. James 2416 Peck St., Muskegon Heights 49444
Stuk, Ronald L...Med. Arts Ctr., #103, Muskegon 49440
Swanson, Raymond E.............1315 Ruddiman Ave., North Muskegon 49445
Swedenburg, Robt. D...1470 Peck Street, Muskegon 49441
Swenson, Leland L.......1706 Peck St., Muskegon 49441
Tellman, H. Clay.........315 W. Clay, Muskegon 49440
Torrey, R. K.....Westgate Medical Bldg., Muskegon 49441
Toy, Chas. M...........1067 Pine St., Muskegon 49442
Tyler, Wm. H...........1435 Peck St., Muskegon 49441
Vandervelde, C. A........1470 Peck St., Muskegon 49441
Vangelder, Wm. C...Medical Arts Center, Muskegon 49440
Voikos, Geo. A..............1470 Peck, Muskegon 49441
Wagenaar, Edward H...3054 Henry St., Muskegon 49444
Welch, Norman L.........Mercy Hosp., Muskegon 49443
White, Warren G., Jr...........307 Westgate Med. Twr., Muskegon 49441
Wiersma, Silas C. (A).............University Hospital, Ann Arbor 48104
Wildgen, Bernard C. Medical Arts Center, Muskegon 49440
Wilke, Carl A. (R)....116B Warren AFB, c/o Maj. J. E. LaRue, Cheyenne, Wyo. 82003
Williams, Dale L.........1692 Peck St., Muskegon 49441
Williams, Edward V.....................2501 Baker St., Muskegon Heights 49444
Wilson, B. David (A)......15428 Archdale, Detroit 48227
Wolters, Burton J...103 Medical Arts Ctr., Muskegon 49440
Young, Malcolm C......1700 Clinton St., Muskegon 49442

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Decker, J. C................52 Maple S.E., Grant 49327
DeKryger, Maynard......220 W. Pine St., Fremont 49412
Deur, Theodore R...........52 Maple S.E., Grant 49327
De Young, Jess..........111 W. Dayton, Fremont 49412
Emerick, Robt. W................Box 147, Fremont 49412
Geerlings, Lambert J. (L)..........194 N. Hillcrest Dr., Fremont 49412
Klein, J. Paul.............P.O. Box 111, Fremont 49412
Masters, Brooker L.......111 W. Dayton, Fremont 49412
Painter, Robert..............52 Maple S.E., Grant 49327
Paxton, Robt. E.............220 W. Pine, Fremont 49412
Pedelty, Norman...........38 State Rd., Newaygo 49337
Vanden Berg, Tunis........220 W. Pine, Fremont 49412

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F..........Lockwood Hosp., Petoskey 49770
Alm, Bernhard T.......418 Petoskey St., Petoskey 49770
Bingley, Leo J., Jr.......1018 Lindell St., Petoskey 49770
Blum, Benj. B.......1208 E. Mitchell St., Petoskey 49770
Burns, Dean C.................Route 1, Petoskey 49770
Chiu, Robert..............Burns Clinic, Petoskey 49770
Christie, Joseph W............Beaver Island Med. Ctr., St. James 49782
Connaughton, P. J..........Burns Clinic, Petoskey 49770
Conti, Jos. B.........924 E. Mitchell St., Petoskey 49770
Conway, Wm. S............Burns Clinic, Petoskey 49770
Dawson, William A.........Burns Clinic, Petoskey 49770
Drake, Gerald............511 Waukazoo, Petoskey 49770
Elliott, Dean C.............Burns Clinic, Petoskey 49770
Foster, Bradford S.........226 Park Ave., Petoskey 49770
Frye, Sanders A............Burns Clinic, Petoskey 49770
Grate, Lawrence E...3950 Rosehill Ave., c/o Miss Susan Grate, Cincinnati, Ohio 45229
Hegener, Aloysius J.....1020 Howard St., Petoskey 49770
Homsi, Rateb.........430 S. Main St., Cheboygan 49721
Kiley, James A..............310 9th St., Manistee 49660
Kirk, Thomas R. (A) 2222 Fuller Road, Ann Arbor 48105
Knecht, Richard A.........226 Park Ave., Petoskey 49770
Kutcipal, R. A...............211 Sunset, Petoskey 49770
Larson, Walter E........456 S. Huron, Cheboygan 49721
Lentini, Nicholas.....................Cheboygan 49721
Lignell, John H.......R. 3, Division St., Charlevoix 49720
Martin, Robt. G...........707 Bridge, Charlevoix 49720
Mateskon, Victor S.........Sunset Blvd., Petoskey 49770
Mayne, Frederick C. (L) P. O. Box 387, Cheboygan 49721
McCullough, W. L........115 Clinton St., Petoskey 49770
McEnroe, John E....1005 E. Mitchell St., Petoskey 49770
McKnight, Robt. D........Lincoln Place, Petoskey 49770
Mertz, Joanne E.............Resort Pike, Petoskey 49770
O'Keefe, N. Thomas.........516 Bay St., Petoskey 49770
Peckham, Richard C...............3480 Hillcrest Circle, Carlsbad, Ca. 92008
Postle, Jack R.........Arlington Heights, Petoskey 49770
Rauch, Carl T.......420 Riverside Dr., Cheboygan 49721
Reus, Leonard W.........226 Park Ave., Petoskey 49770
Rodger, John R.........................Bellaire 49615
Ryan, Mary Harmon..........1705 Chief Okemos Circle, Okemos 48864
Saltonstall, G. B. (L)...112 Clinton St., Charlevoix 49720
Savory, John H......................East Jordan 49727
Shanahan, Robt. E.....1125 Valley View, Petoskey 49770
Sheets, John A.............929 Michigan, Petoskey 49770
Simard, J. E. Henri....Pennsylvania Plaza, Petoskey 49770
Smith, James R...........901 Spruce St., Petoskey 49770
Snide, Rollin F.......125 N. Main St., Cheboygan 49721
Stringham, James R. (L) 225 Backus St., Cheboygan 49721
Tanton, John H............Burns Clinic, Petoskey 49770
Taylor, Robt. M...........Lincoln Place, Petoskey 49770
Tsaloff, Victor.............Burns Clinic, Petoskey 49770
Uhlich, Gustav A.........E. Mitchell Rd., Petoskey 49770
Van Dellen, Jerrian........Water St., East Jordan 49727
Vanden Brink, R. D.........Burns Clinic, Petoskey 49770
Weber, Richard............Burns Clinic, Petoskey 49770
Webster, Jean H..........200 Sunset St., Petoskey 49770
Weburg, Kathryn D............Route 3, Petoskey 49770
Zipf, Charles (A)..1326 S. Park Blvd., Freeport, Ill. 61032

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C.....1405 Pontiac St. Bk., Pontiac 48058
Abbrecht, Martin M.....800 S. Adams, Birmingham 48011
Adair, Robin..........800 S. Adams, Birmingham 48011
Adelson, Seymour S...............20905 Greenfield Rd., Southfield 48075
Albert, Donald G...3535 W. 13 Mile Rd., Royal Oak 48072
Albrecht, Robt. W..................2111 Cass Lake Rd., Keego Harbor 48033
Alexander, Joseph B. (A)..........900 Woodward Ave., Pontiac 48053
Alkar, Yasar M.................159 Pierce St., No. 202, Birmingham 48011
Alshabkhoun, Adnan.33100 12 Mile Rd., Farmington 48024
Andrakovich, F.......5554 Lahser Rd., Birmingham 48010
Angammal, N. (A)....Pontiac State Hosp., Pontiac 48053
Aragones, Jaime V..134 W. University Dr., Rochester 48063
Arena, Joseph A., Jr..............31815 Southfield Rd., Birmingham 48009
Arnkoff, Harry..............150 E. Long Lk. Rd., #106, Bloomfield Hills 48013
Arons, Roy E.......7133 Lindenmere, Birmingham 48010
Ashare, Raymond...........35 S. Johnson, Pontiac 48053
Atash, Manou C..........4173 Brandywine, Troy 48084
Aulie, Hal G......3535 W. 13 Mile Rd., Royal Oak 48072
Avaregan, Mohsen............6707 Heather Heath Ln., Birmingham 48010
Avci, Mustafa..6846 Cooley Lake Rd., Union Lake 48085
Awes, Lorraine E.......500 W. Huron St., Pontiac 48053
Ayrom, Kambiz........19827 Monte Vista, Detroit 48221
Baier, Kurt....3816 Crestlake Dr., Bloomfield Hills 48013
Baker, Frederick A. (L)..........1936 W. Anklam Rd., Tucson, Az. 85705
Balian, John V...........134 W. University Drive # 201, Rochester 48063
Bannow, Robt. J.....880 Woodward Ave., Pontiac 48053
Barker, Chas. P.....214 Wabeek Bldg., Birmingham 48011
Barker, Howard B. (L)................490 Martell Dr., Bloomfield Hills 48013
Barlow, Peter P...31815 Southfield Rd., Birmingham 48009
Barnes, Bradley T........312 Maywood, Rochester 48063
Barnes, Donald J. (L)..20 Norwich, Pleasant Ridge 48069
Barr, Norman L................965 Orchard Ridge Rd., Bloomfield Hills 48013
Barrett, John L.............3535 W. 13 Mile Rd., #608, Royal Oak 48072
Barron, Robert A...............4256 Orchard Lake Rd., Orchard Lake 48033
Barsch, Henry J..............21634 E. Valley Wds. Dr., Birmingham 48010
Bauer, Bruce D.....3229 Woodward Ave., Berkley 48072
Bauer, Edward G........101½ N. Saginaw, Pontiac 48058
Bauer, Ernest W., Sr. (L)........3229 Woodward Ave., Berkley 48072
Bauer, E. William...3229 Woodward Ave., Berkley 48072
Bauer, Franz.........909 Woodward Ave., Pontiac 48053
Baylis, Shelby M...........35 S. Johnson, Pontiac 48053
Beattie, Willard G. (R).............2500 Sample Rd., Pompano Beach, Fl. 33064
Beauregard, Wm. L...............3535 W. 13 Mile Rd., Royal Oak 48072
Beck, Otto O. (L)..308 Wabeek Bldg., Birmingham 48011
Becker, Paul M....1890 Southfield Rd., Birmingham 48009
Belknap, Warren F. 1809 S. Main St., Pleasant Ridge 48069

Benjamin, Durand, Jr. (A)........Pontiac General Hosp., Pontiac 48053
Benoit, Merrill P...Pontiac Mtr. Div., GMC, Pontiac 48053
Berg, Richard M......880 Woodward Ave., Pontiac 48053
Berger, Chas. J..........1500 Linwood, Royal Oak 48067
Berman, Bernard D. 1200 N. Telegraph Rd., Pontiac 48053
Berman, Gilbert M......24601 Coolidge, Oak Park 48237
Beuker, John T.............15901 W. 9 Mile Rd., #206, Southfield 48075
Beyer, Hans A........5675 Kolly Rd., Birmingham 48010
Birkelo, Carl H...4680 Dixie Hwy., Drayton Plains 48020
Blakeney, James R.........17 Utica Road, Pontiac 48053
Blanco, Maximino J. (A)..........Pontiac State Hosp., Pontiac 48053
Bloomberg, Sanford..............23023 Orchard Lk. Rd., Farmington 48024
Blue, Jane............19125 Hillcrest, Birmingham 48009
Boesky, Malcolm D..............26789 Woodward Ave., Huntington Wds. 48070
Boileau, Thornton I...............2075 E. 14 Mile Rd., Birmingham 48008
Bolton, Alan E. (A)..............3601 W. 13 Mile Rd., Royal Oak 48072
Bookmyer, Robt. M...............31815 Southfield Rd., Birmingham 48009
Boss, Peter E. (A)...............3601 W. 13 Mile Rd., Royal Oak 48072
Boucher, Roman E.............4200 N. Woodward Ave., Royal Oak 48072
Boutros, Nabil R..134 W. University Dr., Rochester 48063
Bowers, Chas. L.....909 Woodward Ave., Pontiac 48053
Bradley, Geo. T...3535 W. 13 Mile Rd., Royal Oak 48072
Brady, Neal C.....3535 W. 13 Mile Rd., Royal Oak 48072
Brantley, Robt. E. (A)..............31260 E. Rutland, Birmingham 48009
Brogan, Edward (A).900 Woodward Ave., Pontiac 48053
Bronson, Wm. W.....................28119 John R St., Madison Heights 48071
Brown, Arnold L...........35 S. Johnson, Pontiac 48053
Bryan, Henry G.........22100 Coolidge, Oak Park 48237
Bryan, John B.....4045 W. 13 Mile Rd., Royal Oak 48072
Bryant, F. W.....3535 W. 13 Mile Rd., Royal Oak 48072
Budd, Alexander S. Z...............3511 Lakecrest Dr., Bloomfield Hills 48013
Buehrig, Robert C...........5790 M 15, Clarkston 48016
Bullard, R. W., Jr...........5790 M 15, Clarkston 48016
Bunto, William G.......5965 Orion Rd., Rochester 48063
Burger, John H...31815 Southfield Rd., Birmingham 48009
Burgess, Bruno........29250 Longview St., Warren 48093
Burke, Chauncey G......35 W. Huron St., Pontiac 48058
Burtka, Joseph F..16505 John R St., Madison Hgts. 48071
Byberg, Robt. A...3535 W. 13 Mile Rd., Royal Oak 48072
Cabrera, G. P.....3535 W. 13 Mile Rd., Royal Oak 48072
Calhoun, Ethel T. (L)..............707 Lakeview Ave., Birmingham 48009
Calver, David R. (A)............Pontiac Gen. Hospital, Pontiac 48053
Campbell, K. N..................1465 Cedar Bend Dr., Bloomfield Hills 48013
Campbell, Malcolm D. (R).........435 Ridgewood Rd., Key Biscayne, Fl. 33149
Carioni, Juan C. (A)............Wm. Beaumont Hosp., Royal Oak 48072
Carlisle, Jos. D....3535 W. 13 Mile Rd., Royal Oak 48072
Carlson, Barbara F. (A)........St. Joseph Mercy Hosp., Pontiac 48053
Carpenter, G. B., Jr. 622 N. Woodward, Birmingham 48011
Carrow, Joyce M. (A)............1469 Highmoor Way, Bloomfield Hills 48013
Cashman, Edward F.....18715 Bretton Dr., Detroit 48223
Castedo, Nicanor F...............4189 Sunningdale Dr., Bloomfield Hills 48013
Cecchini, Richardo E. (A)........3601 W. 13 Mile Rd., Royal Oak 48072
Cefai, Anthony F...........35 S. Johnson, Pontiac 48053
Cerkez, C. T.........134 W. University, Rochester 48063
Chandler, Douglas 1890 Southfield Rd., Birmingham 48009
Chandler, Jos. H.............309 Northland Med., Bldg., Southfield 48075
Cheng, James T. (R)...............30 Molly Stark Dr., Morristown, N.J. 07960
Cherup, Nicholas....Pontiac General Hosp., Pontiac 48053
Childers, Merle A..134 W. University Dr., Rochester 48063
Chisa, Neldagae................26711 Woodward Ave., Huntington Wds. 48070
Chow, Cynthia................1969 Hunters Ridge Dr., Bloomfield Hills 48013
Chung, Tai (A)......Pontiac State Hosp., Pontiac 48053
Clair, Alvin H. (M)............1195 Veltre Circle S.W., Atlanta, Ga. 30311
Clarke, Harriet A.............488 S. Fox Hills Drive #3, Bloomfield Hills 48013
Cline, Alan L......4299 Roseberry, Drayton Plains 48020
Cobb, Thos. H.......880 Woodward Ave., Pontiac 48053
Cohen, Carl J.....909 Woodward, No. 110, Pontiac 48053
Cohen, Daniel H...20905 Greenfield Rd., Southfield 48075
Cohen, Jack J........17226 Adrian Rd., Southfield 48075
Cohen, Lewis..26602 Dundee Rd., Huntington Wds. 48070
Cohen, Melvin F. 28590 Rivercrest Drive, Southfield 48075
Colakoglu, Celal..........2669 Coolidge, Berkley 48072
Collins, Edward F........35 W. Huron St., Pontiac 48058
Condon, Frank J...27725 Greenfield Rd., Southfield 48075
Conrad, Cecil D...............3027 N. Woodward Ave., Royal Oak 48072
Cooksey, Norton J. 3535 W. 13 Mile Rd., Royal Oak 48072
Cooley, Roy V...........318 S. Blvd. West, Pontiac 48053
Cooper, Edmond L.............4200 N. Woodward Ave., Royal Oak 48072
Cooper, Robt. S...............3027 N. Woodward Ave., Royal Oak 48072
Corrigan, K. E., Ph.D. (A)............300 Warren Court, Birmingham 48009
Coskey, Ralph J.........22100 Coolidge, Oak Park 48237
Coucke, Henry O. (R)............30785 Woodgate Dr., Southfield 48075
Counts, Robert W................155 Reddingwood Dr., Rochester 48063
Crum, Roger E.............35 S. Johnson, Pontiac 48053
Cutler, Robert M.....909 Woodward Ave., Pontiac 48053
Cutler, Wm. M.....800 S. Adams Rd., Birmingham 48011
Dahlgren, Carl W. (L).............3023 Orchard Lake, Keego Harbor 48033
Darling, C. G., Jr.....880 Woodward Ave., Pontiac 48053
Darnley, James D...............26711 Woodward Ave., Huntington Woods 48070
Dawson, Donald N....Pontiac State Hosp., Pontiac 48053
Dayton, Richard C...............427 W. University Dr., Rochester 48063
Deighton, Murray N...........23023 Orchard Lake Rd., Farmington 48024
Delaney, Malcolm J...........23023 Orchard Lake Rd., Farmington 48024
De Lawter, Hilbert H.............3535 W. 13 Mile Rd., Royal Oak 48072
Delevie, Jacob B.........640 Riker Bldg., Pontiac 48058
Derr, J. William..3535 W. 13 Mile Rd., Royal Oak 48072
Deutsch, Wm. L...600 W. 11 Mile Rd., Royal Oak 48067
De Vito, H. Louis.......3115 Angelus Dr., Pontiac 48055
Dinger, David H...2561 Elizabeth Lk. Rd., Pontiac 48054
Dito, William R.....Pontiac General Hosp., Pontiac 48053
Dobski, Edwin J.....909 Woodward Ave., Pontiac 48053
Doerr, Louis E., Jr...1413 S. Washington, Royal Oak 48067
Donnelly, Wm. J...909 Woodward Avenue, Pontiac 48053
Dooley, William D......35 S. Johnson St., Pontiac 48053
Dorostkar, Massoud....4821 Sedgemoor, Royal Oak 48073
Dorsey, John M., Jr...............31815 Southfield Rd., Birmingham 48009
Drew, Dale R........909 Woodward Ave., Pontiac 48053
Drogowski, Edward J..134 W. University, Rochester 48063
Duhamel, Peter A.....1055 Stellma Lane, Rochester 48063
Dunlap, Gregg L...............2870 Orchard Lake Rd., Keego Harbor 48033
Dunn, Lewis E......3924 Twelve Mile Rd., Berkley 48072
Durak, Gerald G...7105 Sherwood Dr., Birmingham 48010
Durocher, Normand E.......35 S. Johnson, Pontiac 48053
Dustin, Robt. W.....1314 W. Lincoln, Birmingham 48009
Elder, Edward E., Jr........1116 Voorheis, Pontiac 48054
Elliott, Robt. N...3535 W. 13 Mile Rd., Royal Oak 48072
Elton, Richard F..........15901 W. 9 Mile Rd., #620, Southfield 48075
Endress, Z. F., Jr...........35 S. Johnson, Pontiac 48053
Engel, John B. (R).....15463 Asbury Park, Detroit 48227

Ensroth, Jack F....1100 N. Woodward, Birmingham 48011
Ergin, Nevit O.....................860 Lone Pine Rd., Bloomfield Hills 48013
Esslinger, John O..............622 N. Woodward Ave., Birmingham 48011
Esslinger, Valentine..........3535 W. Thirteen Mi. Rd., Royal Oak 48072
Estanislao, A. P.............5790 M 15, Clarkston 48016
Evseeff, Geo. S.....3535 W. 13 Mile Rd., Royal Oak 48072
Farah, Jalil........3525 Brookside, Bloomfield Hills 48013
Fargher, Robert A...660 South Boulevard E., Pontiac 48053
Feldstein, Jerome E. (A).......3601 West 13 Mile Rd., Royal Oak 48072
Fidler, Wm. F.....1200 N. Telegraph Rd., Pontiac 48053
Fink, L. Jerome........500 W. Huron St., Pontiac 48053
Finkell, Lawrence J...15231 W. 7 Mile Rd., Detroit 48235
Finkelstein, Lionel......577 Arlington, Birmingham 48009
Fishman, Gordon R. A...25717 Coolidge, Oak Park 48237
Flaharty, Wm. J. 25000 W. Ten Mile Rd., Southfield 48075
Flanagan, Paul....540 Weybridge, Bloomfield Hills 48013
Fleurquin, A. G..................4415 Park Lane Ct., Bloomfield Hills 48013
Flick, John R.......120 W. Second St., Royal Oak 48067
Fox, Ralph M.......800 S. Adams Rd., Birmingham 48011
Franco, Napoleon.....Pontiac State Hosp., Pontiac 48053
Freedman, Arthur M...........20100 West 12 Mile Rd., Southfield 48075
Frey, James L............Northland Med. Bldg., #704, Southfield 48075
Furlong, Harold A. (L)..35 S. Johnson Ave., Pontiac 48053
Fushman, John A..............4200 N. Woodward Ave., Royal Oak 48072
Gaba, Howard B...8245 Hendrie, Huntington Woods 48070
Gaber, Ben......10831 W. Ten Mile Rd., Oak Park 48237
Gadbaw, Jos. J.....33925 Oakland St., Farmington 48024
Gaensbauer, F.............1965 N. Hammond Lake Rd., Pontiac 48053
Gagliardi, R. A.......880 Woodward Ave., Pontiac 48053
Galens, Gilbert J. 31815 Southfield Rd., Birmingham 48009
Galpin, Richard R...525 Southfield Rd., Birmingham 48009
Garber, Max J.................23023 Orchard Lake Rd., Farmington 48024
Garland, Donald M..........Pont. Motor, Glenwood Av., Pontiac 48053
Gates, Edward M.....Harbin Clinic, Rome, Georgia 30161
Gates, Joann M.......65 S. Telegraph Rd., Pontiac 48053
Gatley, Leslie W...........35 W. Huron St., Pontiac 48058
Gause, Richard C. 31815 Southfield Rd., Birmingham 48009
Gayles, Carlos B. (A)..........473 Kuhn, Pontiac 48057
Gehringer, Norman F..........2335 S. Commerce Rd., Walled Lake 48088
Geist, Edgar J., Jr.....1500 Walton Blvd., Rochester 48063
Gell, James W.........35 S. Johnson Ave., Pontiac 48053
Gelstein, Lazaro......909 Woodward Ave., Pontiac 48053
Gelzayd, Eugene A..20905 Greenfield Rd., Southfield 48075
Gerber, George R. 310 W. University Dr., Rochester 48063
Gerls, Frank B. (L)...4425 Motorway Dr., Pontiac 48054
Gibson, Wellington C....206 E. Commerce, Milford 48042
Gill, Matthew J..........1030 Riker Bldg., Pontiac 48058
Glen, Harold..........26684 Grand River, Detroit 48240
Goerner, Dorothy M. (A)..338 Pilgrim, Birmingham 48009
Goldberg, Howard S..............24777 Greenfield Rd., Southfield 48075
Goldstein, Herbert..22100 Coolidge Hwy., Oak Park 48237
Good, Wayne T...3306 Auburn Rd., Auburn Heights 48057
Goode, Norman J., Jr.....2000 Second Ave., Detroit 48226
Gordon, Clayton H..............1099 N. Cranbrook Rd., Birmingham 48009
Gordon, Seymour..3535 W. 13 Mile Rd., Royal Oak 48072
Gradolph, Paul L...23338 Woodward Ave., Ferndale 48220
Gray, Murray H.........22100 Coolidge, Oak Park 48237
Grayson, Joseph R..........156 Palmer St., Pontiac 48053
Green, J. Donald....217 Briggs Bldg., Birmingham 48011
Green, Ralph S.........24100 Stratford, Oak Park 48237
Green, Willard M...........35 S. Johnson, Pontiac 48053
Grekin, John N...........15901 W. 9 Mile Rd., #620, Southfield 48075
Grekin, Thos. D...3535 W. 13 Mile Rd., Royal Oak 48072
Gurol, Feridun....32316 Grand River, Farmington 48024
Gustafson, David C..............3535 W. 13 Mile Rd., Royal Oak 48072
Gustafson, Everette..........35 S. Johnson, Pontiac 48053
Gutterman, Meyer A.............25085 Coolidge Hwy., Oak Park 48237
Haanes, Merle A......909 Woodward Ave., Pontiac 48053
Hague, Gilbert W..................739 Westview Rd., Bloomfield Hills 48013
Halsted, Lee H................23023 Orchard Lake Rd., Farmington 48024
Hambalgo, George J.
Hamburger, Joel I...20905 Greenfield Rd., Southfield 48075
Hamilton, Quentin P...20905 Greenfield, Southfield 48075
Han, Maolin....3358 Auburn Rd., Auburn Heights 48057
Harmon, Lewis G. 1775 E. 14 Mile Rd., Birmingham 48008
Harrold, John A.........534 Franklin Rd., Pontiac 48053
Harvey, Campbell (L)..........San Miguel DeAllende, APTADO, Postal 127, Guanajuato, Mexico
Hasegawa, Carl M......1800 Tuxedo Ave., Detroit 48206
Hassberger, John B.............620 N. Woodward Ave., Birmingham 48011
Hathaway, Wm. S...........433½ Main, Rochester 48063
Hayden, H. S., Ph.D. (A)............300 Warren Court, Birmingham 48009
Hecht, Manes S.....................26711 Woodward, Huntington Woods 48070
Heitsch, Joseph F. (A)..3860 Lonedale Rd., Pontiac 48057
Henderson, H. R...33750 Freedom Rd., Farmington 48024
Henderson, James E...909 Woodward Ave., Pontiac 48053
Henderson, Worth W...............1307 S. Washington, Royal Oak 48067
Hendren, Owen S.............880 Woodward Ave., #19, Pontiac 48053
Hendricks, Frank R...............21701 W. 11 Mile Rd., Southfield 48075
Henry, Colonel R. (L)............125 W. Nine Mile Rd., Ferndale 48220
Hensley, Chas. B.....248 S. Broadway, Lake Orion 48035
Herman, Edward L........909 Woodward, Pontiac 48053
Hermes, Charles R................4680 Dixie Highway, Drayton Plains 48020
Hess, Richard L. (A)............Pontiac Gen. Hospital, Pontiac 48053
Heyboer, Donald J...St. Joseph Mercy Hosp., Pontiac 48053
Hill, William E..........534 Franklin Rd., Pontiac 48053
Hoekman, Aben (R)..........1740 Hamilton Dr., Rte. 3, Pontiac 48053
Hoffman, Lawrence D......20150 Audrey, Detroit 48235
Holmes, Keith M.....880 Woodward Ave., Pontiac 48053
Hopkins, Melvin, Jr.....900 Baldwin Ave., Pontiac 48055
Hopkins, Wm. J..............17000 W. Eight Mile Rd., Southfield 48075
Howard, Marjorie E. (A).........Pontiac General Hosp., Pontiac 48053
Howell, Lynn E......909 Woodward Ave., Pontiac 48053
Hrushka, Myroslaw....Pontiac State Hosp., Pontiac 48053
Hsu, John J.................35 W. Huron St., Pontiac 48058
Hubert, John R.......880 Woodward Ave., Pontiac 48053
Ignatius, Aram A...1915 E. Nine Mile Rd., Ferndale 48220
Ingold, John A.......3535 W. Thirteen Mile Rd., # 608, Royal Oak 48072
Isaac, Herbert L...909 Woodward Ave., 115, Pontiac 48053
Isgut, Robert D.........28477 Hoover Rd., Warren 48093
Izenstark, J. L.................Cedars Sinai Med. Ctr., 4833 Fountain Ave., Los Angeles, Ca. 90029
Jackson, Philip J..........23480 Church, Oak Park 48237
Jacobi, Rodman C.......91 S. Washington, Oxford 48051
Jacobson, Herbert S.............20905 Greenfield, #400, Southfield 48075
Jagnow, Nanette...525 Southfield Rd., Birmingham 48009
James, Robt. E., Jr...2561 Elizabeth Lk. Rd., Pontiac 48054
James, Thomas P.....1387 Chesterfield, Birmingham 48009
Jenkins, Henry L............161 State St., Pontiac 48053
Jennings, John A...21707 W. 11 Mile Rd., Southfield 48075
Johnson, Clare G...909 S. Woodward Ave., Pontiac 48053
Johnson, J. Frederic...............23760 N. Woodward, Pleasant Ridge 48069
Johnson, James W.....2581 McClintock Rd., Pontiac 48053
Johnson, Robert H...............310 W. University Dr., Rochester 48063

Jones, Cyril D..............100 W. Hickory Grove Rd., Bloomfield Hills 48013
Joseph, Antoine L...4045 W. 13 Mile Rd., Royal Oak 48072
Joyce, John A.......413 Woodward Ave., Rochester 48063
Jury, Donald B. 1126 S. Woodward Ave., Royal Oak 48067
Kadian, George....20905 Greenfield Rd., Southfield 48075
Kamm, Robert L.......240 Daines St., Birmingham 48009
Karakuc, Raymond J.............Wm. Beaumont Hosp., Royal Oak 48072
Katz, Allan M. (A)....461 W. Huron St., Pontiac 48053
Katz, Sidney F...........17350 Dorset, Southfield 48075
Kaufman, Jack M...............26711 Woodward Ave., Huntington Woods 48070
Kay, Sherman A.....1026 S. Washington, Royal Oak 48067
Kaylor, Marietta J. (A)........2435 Elizabeth Lake Rd., Pontiac 48053
Kazdan, Louis L. 13801 W. Nine Mile Rd., Oak Park 48237
Keeffe, Eugene J..............468 W. Williamsbury Rd., Birmingham 48010
Kemp, Felix J........880 Woodward Ave., Pontiac 48053
Kendrick, H. F., Jr.........35 S. Johnson, Pontiac 48053
Kerr, Edwin C.......32749 Franklin Rd., Franklin 48025
Ketchum, Jesse....120 W. 11 Mile Rd., Royal Oak 48068
Kettler, Hans J.....25160 Edgemont Rd., Southfield 48075
Khaneja, Satish C...140 Elizabeth Lake Rd., Pontiac 48053
Khodadadeh, B.................4252 Orchard Lake Rd., Orchard Lake 48033
Kilar, Theodore W................31815 Southfield Rd., Birmingham 48009
Kinsley, George......909 Woodward Ave., Pontiac 48053
Klass, Arthur......1026 S. Washington, Royal Oak 48067
Klegman, Jerome H...........17000 W. Eight Mile Rd., Southfield 48075
Klein, Marvin E............18400 W. Twelve Mile Rd., Southfield 48075
Klewicki, H. A........22720 Woodward, Ferndale 48220
Knights, Edwin M., Jr...16001 9 Mile Rd., Southfield 48075
Knox, Richard S. 422 Washington Sq. Pl., Royal Oak 48067
Koehler, Wm. H...3535 W. 13 Mile Rd., Royal Oak 48072
Koerner, Karl F...........1820 Crooks Rd., Troy 48084
Koltonow, Lawrence..........304 Northland Med. Bldg., Southfield 48075
Kornmesser, James G...........23023 Orchard Lake Rd., Farmington 48024
Korotney, Frank S. (A)...63 Charles Lane, Pontiac 48053
Kothari, Ujamlal C....Pontiac State Hosp., Pontiac 48053
Kozlow, Clifford S...1201 Brookwood, Birmingham 48009
Kozlow, L. Ange............3535 W. Thirteen Mi. Rd., Royal Oak 48072
Kozonis, Michael C....880 Woodward Ave., Pontiac 48053
Kozora, Elmer J...17650 W. 12 Mile Rd., Southfield 48075
Krane, Mark..2335 S. Commerce Rd., Walled Lake 48088
Kreindler, Alfred M.....200 Elm St., Birmingham 48008
Kresge, Bruce A.....1500 Walton Blvd., Rochester 48063
Krieger, Norman N.........402 Union St., Milford 48042
Krohn, Don R. 23023 Orchard Lake Rd., Farmington 48024
Kuhel, Eli H.........25415 Southfield, Southfield 48075
Kuhn, Anne K...4203 W. 13 Mile Rd., Royal Oak 48072
Kuhn, Robt. E.....4203 W. 13 Mile Rd., Royal Oak 48072
Kumar, G. Krishna (A)..........3601 W. 13 Mile Rd., Royal Oak 48072
Kurnetz, Ruben..10831 W. Ten Mile Rd., Oak Park 48237
La Ban, Myron M.........31815 Southfield Road # 32, Birmingham 48009
Labes, James....15101 W. McNichols Rd., Detroit 48235
Ladd, James E.....31815 Southfield, Birmingham 48009
Lahti, Paul T.....3600 W. 13 Mile Rd., Royal Oak 48072
Lambert, Alvin G. 3535 W. 13 Mile, 505, Royal Oak 48072
Lanard, Francis W...31504 Sunset Dr., Birmingham 48009
Landers, James W....................1670 Keller Lane, Bloomfield Hills 48013
Landry, Roy A.........5770 S. Main St., Clarkston 48016
Laporte, Lawrence A.....Ford Motor Co., P.O. Box 570, Warren 48090
Larson, Alvin R......880 Woodward Ave., Pontiac 48053
Laskey, Gary M. (A).900 Woodward Ave., Pontiac 48053
Laux, Philip J., Jr...3027 N. Woodward, Royal Oak 48072
Lawson, James M.....2605 W. Grand Blvd., Detroit 48208
Laxa, Antonio A..........14 Edgelake, Union Lake 48085
Layman, Douglas C...............3535 W. 13 Mile Rd., Royal Oak 48072
Leach, Chas. A., Jr. 525 Southfield Rd., Birmingham 48009
Leahy, Etta Link (R)......1616 Wiltshire, Berkley 48072
Leichtman, R. R.............5770 M 15, Clarkston 48016
Lessien, Bruce T. 4045 W. Thirteen Mile, Royal Oak 48072
Levin, Murray B...7046 Cathedral Dr., Birmingham 48010
Levine, Bernard..................25835 Parkwood Dr., Huntington Woods 48070
Levine, Robert S. (A) 900 Woodward Ave., Pontiac 48053
Lewis, Sol M. (L).....541 W. Oakridge, Ferndale 48220
Lichtwardt, Harry E...............3535 W. 13 Mile Rd., Royal Oak 48072
Lichtwardt, John R...............3535 W. 13 Mile Rd., Royal Oak 48072
Lievois, Edward G.................289 Westbourne Dr., Birmingham 48010
Lilly, Richard J.....25336 Castlereigh, Farmington 48024
Limia, Antonio G...25 Martell Dr., Bloomfield Hills 48013
Ling, T. W.....23607 Farmington Rd., Farmington 48024
Linn, Herman J...3601 W. 13 Mile Rd., Royal Oak 48072
Liu, Henry Y...16001 W. Nine Mile Rd., Southfield 48075
Longyear, Harold W..............3535 W. 13 Mile Rd., Royal Oak 48072
Lovell, James R. (A)........3601 W. Thirteen Mile Rd., Royal Oak 48072
Lowell, James W.....1260 Lyonhurst, Birmingham 48009
Lowery, Anthony J. (R)................8689 Golf Lane, Union Lake 48085
Lundy, Ray O. (A).Pontiac Gen. Hospital, Pontiac 48053
Lupovitch, Aaron........24661 Kenosha, Oak Park 48237
Lussos, A. S......2707 Bridle Rd., Bloomfield Hills 48013
Lutes, Byron B.............1232 Heyden, Pontiac 48054
Lutikof, Blagoy (A)..900 Woodward Ave., Pontiac 48053
Lyons, Robt. T............35 S. Johnson, Pontiac 48053
Mackey, George S. 3601 W. 13 Mile Rd., Royal Oak 48072
Mahrt, Delmar H.............Wm. Beaumont Hospital, 3601 West 13 Mile Rd., Royal Oak 48072
Malarney, Wm. F...........880 Woodward Ave., #106, Pontiac 48053
Manz, Howard N.............23023 Orchard Lake Rd., Farmington 48024
Marcotte, Oliver J. (R)..........25000 W. Ten Mile Rd., Southfield 48075
Margulis, R. Ralph...31815 Southfield, Birmingham 48009
Markley, John M.....4120 Sandylane, Birmingham 48010
Maroko, Simon W.........2416 Avondale, Pontiac 48053
Marra, John J..............35 S. Johnson, Pontiac 48053
Marsa, Percy S.....785 N. Lapeer Rd., Lake Orion 48035
Marshall, Joseph F. (A)........900 Woodward Avenue., Pontiac 48053
Martin, Donald W.....Pontiac State Hosp., Pontiac 48053
Martin, Francis A.........880 Woodward, Pontiac 48053
Mason, Robt. J. 618 N. Woodward Ave., Birmingham 48011
Mathura, G. R...........212 Riker Bldg., Pontiac 48058
Mayo, W. E. Barry............2338 N. Woodward Ave., Royal Oak 48073
Mayor, Raymond L.........35 S. Johnson, Pontiac 48053
McCain, French H..............628 N. Woodward Ave., Birmingham 48011
McCallon, Talmage D..............1307 S. Washington, Royal Oak 48067
McCandliss, D. H..........35 S. Johnson, Pontiac 48053
McConkie, James P...............2425 W. Lincoln Rd., Birmingham 48009
McDonald, Robert J............4200 N. Woodward Ave., Royal Oak 48072
McElroy, Wm. J., Jr...4520 Robinwood, Royal Oak 48073
McEvoy, Francis J.....1715 Crooks Rd., Royal Oak 48067
McGibbon, Bernard M. (A)........900 Woodward Ave., Pontiac 48053
McHugh, James M. 20905 Greenfield Rd., Southfield 48075
McInerney, Thos. S......2026 Laurome, Royal Oak 48073
McIntyre, Jack B..........625 Purdy, Birmingham 48009
McKinney, Roy J.................3535 W. 13 Mile Rd., Royal Oak 48072
McLaughlin, J. H................604 North Woodward, Birmingham 48011
McNeill, Howard H. (L)........225 W. Hickory Grove, Bloomfield Hills 48013
McPhee, Edward C........909 Woodward, Pontiac 48053
McQuiggan, Mark C...........29653 Club House Lane, Farmington 48024

Megler, Mihael A...3710 S. Darlington, Birmingham 48010
Mehas, Constantine P..............1060 Trailwood Path, Birmingham 48010
Meier, Donald A..20905 Greenfield Rd., Southfield 48075
Meisner, Harry E..24777 Greenfield Rd., Southfield 48075
Menge, Michael S................134 W. University Dr., Rochester 48063
Mercer, Frank A. (L)..............3032 Morningview, Birmingham 48010
Milad, Anis A.......1111 N. Campbell, Royal Oak 48067
Miles, Franklin T...............4631 Shenandoah Ave., Allen Park 48101
Milgrom, Sidney 1229 S. Washington St., Royal Oak 48067
Miller, Arthur C...31723 Waltham Ct., Birmingham 48009
Miller, Hazen L. (L)........Box 247 A, Grayling 49738
Miller, Hubert........28554 Rivercrest, Southfield 48075
Miller, Irving M................23023 Orchard Lake Rd., Farmington 48024
Miller, Sidney........200 Elm Street, Birmingham 48008
Mimura, James T.....31815 Southfield, Birmingham 48009
Mojica, E. D.......140 Elizabeth Lk. Rd., Pontiac 48053
Mojica, Pablo A....140 Elizabeth Lk. Rd., Pontiac 48053
Moloney, James C..................5851 Farmington Rd., Orchard Lake 48033
Montani, Norberto J. (A)......William Beaumont Hosp., Royal Oak 48072
Morin, Leonard A....29929 Vernon Dr., Southfield 48075
Morton, Carl (A)..............3601 West 13 Mile Rd., Royal Oak 48072
Mueller, Elmer J. 31815 Southfield Rd., Birmingham 48009
Mumby, Clinton J................26789 Woodward Ave., Huntington Wds. 48070
Munson, Harry L...............2335 S. Commerce Rd., Walled Lake 48088
Murguz, Atalay M...1625 E. Fourth St., Royal Oak 48067
Murray, Kenneth W...31815 Southfield, Birmingham 48009
Musick, Gordon S...31327 W. Rutland, Birmingham 48009
Nalbandian, Robt. M................5145 Nob Hill Ct., Bloomfield Hills 48013
Nalepa, Eugene J.....880 Woodward Ave., Pontiac 48053
Nathanson, Milton L..............17000 W. 8 Mile Rd., Southfield 48075
Naz, John F........2826 Orange Grove, Waterford 48095
Nazareno, S. G.......2368 Old Salem Rd., Pontiac 48057
Neiswander, Paul L......30001 Van Dyke, Warren 48093
Nessel, Jack H............880 Woodward, Pontiac 48053
Netzel, Robert J...................2700 Colonial Way, Bloomfield Hills 48013
Newby, Burns G.......20905 Greenfield, Southfield 48075
Newcomb, Arnold B...............19834 Riverside Dr., Birmingham 48009
Nichamin, Samuel J..............20905 Greenfield Rd., Southfield 48075
Nicholas, C. T. (A)..900 Woodward Ave., Pontiac 48053
Nickerson, Ivey D...6245 Golfview Dr., Birmingham 48010
Niederluecke, D. C...........35 S. Johnson, Pontiac 48053
Nol, Edward A..........Pontiac St. Hosp., Pontiac 48053
Norzow, Alex J. (A) Pontiac General Hosp., Pontiac 48053
Nosanchuk, Jos. I...........35 S. Johnson, Pontiac 48053
Nunn, James W........751 Chestnut, Birmingham 48008
O'Donnell, C. H...23338 Woodward Ave., Ferndale 48220
Oliphant, Wm. W...785 N. Lapeer Rd., Lake Orion 48035
Olsen, Richard E...................2874 Colonial Way, Bloomfield Hills 48013
O'Neill, James A............5790 M 15, Clarkston 48016
Ormond, John K. (L)..909 Woodward Ave., Pontiac 48053
O'Sullivan, Girardin S...........26520 Willowgreen Way, Franklin 48025
Ott, Harold A...3019 N. Woodward Ave., Royal Oak 48072
Overy, Donald C......880 Woodward Ave., Pontiac 48053
Packard, David C......5770 Highland Rd., Pontiac 48054
Page, Oliver W., Jr. (M)....Bassett Army Hospital, APO, Seattle, Wa. 98731
Palmer, Hayden D. (L)..35 W. Huron St., Pontiac 48058
Paris, S. William..............23023 Orchard Lake Rd., Farmington 48024
Patel, Vishnubhai U. (A)........Pontiac General Hosp., Pontiac 48053
Patrick, Chas. I...4721 Dixie Hwy., Drayton Plains 48020
Patterson, J. C.....3535 W. 13 Mile Rd., Royal Oak 48072
Pauli, Theodore H. (R)............880 Woodward Ave., Pontiac 48053
Payton, Chas. F.......1719 Crooks Rd., Royal Oak 48067
Pear, Erwin G. 3027 N. Woodward Ave., Royal Oak 48072
Pearce, James F...3535 W. 13 Mile Rd., Royal Oak 48072
Peirce, Wm. H.....800 S. Adams Rd., Birmingham 48011
Pelletier, Chas. J.....1111 N. Campbell, Royal Oak 48067
Pensavecchia, J. S...........2680 Garland, Pontiac 48053
Pesaros, Panayotis..............648 N. Woodward Ave., Birmingham 48011
Pfeifer, John R...............15901 W. 9 Mile Rd., 600, Southfield 48075
Pitonyak, A. D.....St. Joseph Mercy Hosp., Pontiac 48053
Plagge, Merle O..................4680 Dixie Highway, Drayton Plains 48020
Pool, Robert, Jr.....800 S. Adams Rd., Birmingham 48011
Porter, Kenneth F. 2709 Bradway Blvd., Birmingham 48010
Portnoy, Harold D.......445 W. Huron St., Pontiac 48053
Ports, Preston W...33108 Grand River, Farmington 48024
Poznanski, Elva O...2662 Salisbury Lane, Ann Arbor 48103
Poznanski, W. A................1100 N. Woodward Ave., Birmingham 48011
Proctor, Bruce....3431 Baldwin Rd., RR4, Pontiac 48055
Proctor, Conrad A...............3535 W. 13 Mile Road, Royal Oak 48072
Quarton, Albert E., Jr. 542 Pilgrim Rd., Birmingham 48009
Quigley, J. Patrick..........31815 Southfld. Rd., #14, Birmingham 48009
Quinn, James R., Jr.................2070 W. Valley Rd., Bloomfield Hills 48013
Rafani, Iraj...3027 N. Woodward Ave., Royal Oak 48072
Ragins, Abner I.......909 Woodward Ave., Pontiac 48053
Ramirez, Ignacio O. (A)..............17380 Lincoln St., East Detroit 48021
Ramirez, Jaime (A)..............16001 W. 9 Mile Rd., Southfield 48075
Ramirez, Joaquin J......751 Chestnut, Birmingham 48008
Ranney, Kenneth I...............3535 W. 13 Mile Rd., Royal Oak 48072
Ravin, Mary A...............31237 Sleepy Hollow Ln., Birmingham 48010
Raynale, George P. (L)..............423 Tooting Lane, Birmingham 48009
Read, James A.....610 N. Woodward, Birmingham 48011
Rech, Wm. R...................2335 S. Commerce Rd., Walled Lake 48088
Reid, Robert E....3535 W. 13 Mile Rd., Royal Oak 48072
Reilly, Richard C......909 Woodward Ave., Pontiac 48053
Rendziperis, N. C. 1100 W. University Dr., Rochester 48063
Reutter, Carolyn..............17600 Northland Pk. Ct., Southfield 48075
Richard, Robert E.....1719 Crooks Rd., Royal Oak 48067
Richards, Wilson P.................3500 W. Maple Rd., Birmingham 48010
Richardson, Robt. P..................26711 Woodward, Huntington Woods 48070
Riggs, Harry L.........149 Franklin Blvd., Pontiac 48053
Riker, Aaron D. (L)......640 Riker Bldg., Pontiac 48058
Risk, Wm. R...................1190 East 12 Mile Road, Madison Heights, Mi. 48071
Rivas, Ricardo A. (A).............Pontiac State Hosp., Pontiac 48053
Rivera, Eduardo......900 Woodward Ave., Pontiac 48053
Roehm, Harold R. (L)..............319 Wabeek Bldg., Birmingham 48011
Romanik, John H.................31601 W. 13 Mile Rd., Farmington 48024
Romero, Lino A...............1880 S. Woodward Ave., Birmingham 48009
Rossin, Herbert W...20905 Greenfield Rd., Southfield 48075
Roth, Herbert J...17640 W. 12 Mile Rd., Southfield 48075
Roumell, Theodore L.............444 W. University Dr., Rochester 48063
Rowley, Laurie G. (L) 2200 Telegraph Rd., Pontiac 48053
Ruesink, Donald E........127 Ferndale, Rochester 48063
Rupp, Edson C., Jr...............3535 W. 13 Mile Rd., Royal Oak 48072
Rush, Alva D., Jr.......391 Hamilton, Birmingham 48011
Ruskin, David S...20905 Greenfield Rd., Southfield 48075
Russell, Vincent P...3535 W. 13 Mile Rd., Royal Oak 48072
Rutzky, Julius....St. Joseph Mercy Hosp., Pontiac 48053

Ruva, Jos. J.......4463 Dixie Hwy., Drayton Plains 48020
Rydesky, Merle F.....16001 W. 9 Mile, Southfield 48075
Sadovsky, Vincent J...880 Woodward Ave., Pontiac 48053
St. John, Harold A. (L)..35 West Huron St., Pontiac 48058
Salisbury, Carolyn S...21580 Greenfield, Oak Park 48237
Samborski, Anne H..32600 Grand River, Farmington 48024
Samet, Norman T.............1100 N. Woodward Ave., Birmingham 48011
Sandhu, Manmohan S. (A)........900 Woodward Ave., Pontiac 48053
Sanford, Glenn A...........35 S. Johnson, Pontiac 48053
Sansone, Thos J......909 Woodward Ave., Pontiac 48053
Satersmoen, Theodore....524 Riker Bldg., Pontiac 48058
Schaefer, Wm. C.........14001 Greenfield, Detroit 48227
Schirle, Jos. L., Jr.......1116 Voorheis Rd., Pontiac 48053
Schneyer, Jerome J.............25000 W. Ten Mile Rd., Southfield 48075
Schoenfeld, Robt. J...800 S. Adams Rd., Birmingham 48011
Scholes, Danl. R...3535 W. 13 Mile Rd., Royal Oak 48072
Schreier, Leonard..909 S. Woodward Ave., Pontiac 48053
Schrock, Marvin E.......35 S. Johnson St., Pontiac 48053
Schuneman, Howard A..........23760 Woodward Ave., Pleasant Ridge 48069
Schwartz, David................33120 W. Twelve Mile, Farmington 48024
Schwartz, Oscar D.........15901 W. 9 Mile Rd., #620, Southfield 48075
Schweinsberg, Stephen......507 Bemis Rd., Saline 48176
Seaborn, Arthur J...............885 N. Woodward Ave., Birmingham 48009
Segula, Robt. L.............35 S. Johnson, Pontiac 48053
Selman, Robert........500 W. Huron St., Pontiac 48053
Sempere, Chas. R...........35 S. Johnson, Pontiac 48053
Sewell, Geo. R.................411 West Ten Mile Rd., Pleasant Ridge 48069
Shadley, Maxwell L........94 Ottawa Dr., Pontiac 48053
Shea, James Joseph........35 S. Johnson, Pontiac 48053
Sheffield, Loren C. (L)....35 S. Johnson, Pontiac 48053
Sheridan, F. Michael............1307 S. Washington St., Royal Oak 48067
Shin, Eon.....1100 W. University Dr., Rochester 48063
Siegel, Marvin D.......445 W. Huron St., Pontiac 48053
Siegel, Peter.........880 Woodward Ave., Pontiac 48053
Siegel, Sheldon N. (M).......5956 Westchester Pk. Dr., College Park, Md. 20740
Siffring, Loren W.....427 W. University, Rochester 48063
Silberg, Joel J.......16800 Greenfield Rd., Detroit 48235
Silvani, John.........909 Woodward Ave., Pontiac 48053
Silver, Marvin D. 3535 West 13 Mile Rd., Royal Oak 48072
Simmons, Paul B. (A)............461 West Huron St., Pontiac 48053
Simpson, Edward K. (L)..............2 Sunset Avenue, Chatham, Ont., Canada
Simpson, John R.........200 Elm St., Birmingham 48008
Sklar, Robert B. (A)............3601 W. 13 Mile Rd., Royal Oak 48072
Smith, Carleton A.....880 Woodward Ave., Pontiac 48053
Smith, Donald S.........1010 Riker Bldg., Pontiac 48058
Smith, Geo. E.....3535 W. 13 Mile Rd., Royal Oak 48072
Sokolowski, M. Z.....2545 Coolidge, Apt. 30A, Troy 48084
Somerville, Wm. J.............3535 W. 13 Mile Rd., 308, Royal Oak 48072
Sosin, Allen..23023 Orchard Lake Rd., Farmington 48024
Spademan, Loren C...............3535 W. 13 Mile Rd., Royal Oak 48072
Spencer, Lloyd H.............1219 S. Washington Ave., Royal Oak 48067
Spiro, Henry J............27046 Pierce, Southfield 48075
Spoehr, Eugene L. 22832 Woodward Ave., Ferndale 48220
Spohn, Earle W. 324 Washington Sq. Pl., Royal Oak 48067
Stageman, John C.........909 Woodward, Pontiac 48053
Stanisavljevic, S...2338 Woodward Ave., Royal Oak 48073
Stanley, Wm. F.....1148 S. Woodward, Royal Oak 48067
Starman, Marvin L.........21701 W. 11 Mile Rd., #10, Southfield 48075
Steffes, Everette M..............3345 Coolidge Highway, Berkley 48072
Stephens, W. H., Jr............602 N. Woodward Ave., Birmingham 48011
Stern, Sheldon D........802 Mutual Bldg., Detroit 48226
Stolpman, A. K.....640 N. Woodward, Birmingham 48011
Stolte, Jon L. (A)........36 Charles Lane, Pontiac 48053
Stone, David Q......Wixom Assembly Plant, P.O. Box 1, Wixom 48096
Stremler, Bernard J...1460 Chesterfield, Birmingham 48009
Stuecheli, Milton B. 1084 Willow Lane, Birmingham 48009
Sutton, Palmer E. (L)....222 Linden, Birmingham 48009
Swartz, Wm. H...............2335 So. Commerce Rd., Walled Lake 48088
Swickle, Edward F...........17 S. Main, Clawson 48017
Swingle, Norman E...............1775 E 14 Mile Rd., Birmingham 48008
Szappanyos, Bela J.............3325 Burning Bush Rd., Birmingham 48010
Tan, Elaine Hartje....367 Old Perch Rd., Rochester 48063
Tan, King L.........367 Old Perch Rd., Rochester 48063
Tan, Thian Lai........1490 North Pine, Rochester 48063
Tanay, Antoinette....114 S. Lafayette, Royal Oak 48067
Tarpinian, Dick A...3535 W. 13 Mile Rd., Royal Oak 48072
Tauber, Abraham......500 W. Huron St., Pontiac 48053
Teich, Kenneth W...........Comm. Prof. & Hosp. Act., 1st National Bldg., Ann Arbor 48108
Teshima, John Y...3535 W. 13 Mile Rd., Royal Oak 48072
Thompson, Wm. C., III (A)........900 Woodward Ave., Pontiac 48053
Thorburn, Allan K.............3377 Elizabeth Lake Rd., Pontiac 48054
Threlkeld, Robert R..............3535 W. 13 Mile Rd., Royal Oak 48072
Tierney, Thomas D. 450 N. Woodward, Birmingham 48011
Timmis, Gerald C...............3535 W. 13 Mile Rd., Royal Oak 48072
Torgerson, Thos. S......751 Chestnut, Birmingham 48008
Touma, Alfred..................26789 Woodward Ave., Huntington Wds. 48070
Trader, Kenneth N.........15901 W. 9 Mile Rd., #720, Southfield 48075
Tregenza, Wm. K......20905 Greenfield, Southfield 48075
Tremblay, Raymond L..............2370 Walton Blvd., Rochester 48063
Trumpour, Donald J...2370 Walton Blvd., Rochester 48063
Tsiatalas, George..4045 W. 13 Mile Rd., Royal Oak 48072
Tubbs, Constance J...........15901 W. Nine Mile Rd., Southfield 48075
Tupper, Robert L..........86 Ottawa Dr., Pontiac 48053
Ulgenalp, Attila O.....909 Woodward Ave., Pontiac 48053
Ullmann, A. S...1101 W. University Dr., Rochester 48063
Ulveling, Robert A.......500 W. Huron St., Pontiac 48053
Underhill, Robert S..............26789 Woodward Ave., Huntington Woods 48070
Urwiller, K. L........909 Woodward Ave., Pontiac 48053
Van De Leuv, John H.............91 S. Washington St., Oxford 48051
Vanden Berg, Kenneth......35 S. Johnson, Pontiac 48053
Vander, Seymour A................20905 Greenfield Rd., Southfield 48075
Van Zoeren, Jay J.................937 Rock Spring Rd., Bloomfield Hills 48013
Varbedian, Thos. G. 195 W. Brown St., Birmingham 48011
Vaught, Richard K.....2009 Crooks Rd., Royal Oak 48073
Veluswamy, V. P. (A)..Pontiac St. Hosp., Pontiac 48053
Von Valtier, Wm. F. ....202 Walnut St., Rochester 48063
Waehneldt, Niels R..................4755 Dover Court, Bloomfield Hills 48013
Wagner, Ruth E. (L)..315 Allen Avenue, Royal Oak 48073
Wake, Douglas L......1406 Woodsboro, Royal Oak 48067
Wallace, Donald B..........909 Woodward Ave., #118, Pontiac 48053
Wallack, Erwin N...............15660 W. Ten Mile Rd., Southfield 48075
Walser, Howard C. (A)...............1300 Northlawn, Birmingham 48009
Wangner, William F................1401 S. Washington, Royal Oak 48067
Ward, W. Paul....3535 W. 13 Mile Rd., Royal Oak 48072
Warner, Fredk. H. O...............3400 Sashabaw Rd., Drayton Plains 48020
Washington, J. E., Jr. (A).........900 Woodward Ave., Pontiac 48053
Watson, Robert M. (M)
Watson, Thos. Y....640 N. Woodward, Birmingham 48011
Weaver, William F. 33750 Freedom Rd., Farmington 48024

Webber, Lynn F. (R)..461 Colonial Ct., Grosse Pte. 48236
Wechsler, Norman....880 Woodward Ave., Pontiac 48053
Wegrzyn, George C...1380 Brookwood, Birmingham 48009
Weingarten, Joel E........18905 Carmona, Southfield 48075
Weintraub, G. S.............3535 W. 13 Mile Rd. 305, Royal Oak 48072
Weintraub, Rosalyn H. (A).........6990 Holiday Drive., Birmingham 48010
Weisman, Lawrence S...................28780 John R, Madison Hgts. 48071
Weiss, Morris...................26339 Woodward Ave., Huntington Woods 48070
Wendling, Dieter..31815 Southfield Rd., Birmingham 48009
Wessels, Robt. R...302 Wabeek Bldg., Birmingham 48011
Westfall, Edwin J...3535 W. 13 Mile Rd., Royal Oak 48072
Westmaas, Wm. J.....................134 Jaikins Bldg., 1100 N. Woodward Ave., Birmingham 48011
White, Daniel B.............1675 Bedford Square #203, Rochester 48063
White, Robert H...384 Hamilton Ave., Birmingham 48011
Wiant, John L.......258 Briggs Bldg., Birmingham 48011
Wigent, Ralph D...........Pont. Motor, Glenwood Ave., Pontiac 48053
Wilkinson, Wm. C.....880 Woodward Ave., Pontiac 48053
Williams, John P............35 S. Johnson, Pontiac 48053
Willis, Maurice E.......500 W. Huron St., Pontiac 48053
Wilson, Paul R. (A)............Pontiac Gen. Hospital, Pontiac 48053
Winkler-Prins, V.................4256 Orchard Lk. Rd., Orchard Lake 48033
Wisniewski, E. M.......950 E. Maple, Birmingham 48011
Wolfe, Warren E. 6290 Wing Lake Rd., Birmingham 48010
Wood, Warren A., Jr...............3535 W. 13 Mile Rd., Royal Oak 48072
Woodward, Hanna L.............Pontiac General Hosp., Pontiac 48053
Woodward, Robert D...........1100 N. Woodward Ave., Birmingham 48011
Yesko, Veldora C..............26075 Woodward Ave., Huntington Wds. 48070
Ylvisaker, John R.....909 Woodward Ave., Pontiac 48053
Youel, David B. (M).......402 Union St., Milford 48042
Young, Arthur R. (L)....35 W. Huron St., Pontiac 48058
Yuzon, Ricardo A. (A)..........140 Elizabeth Lk. Rd., Pontiac 48053
Zimmerman, Walter J...............32340 Sylvan Lane, Birmingham 48009
Zinterhofer, J. J., Jr........17187 Schaefer, Detroit 48235
Zografov, Nikolas S...3648 Rockingham, Royal Oak 48072
Zujko, Alphonse J.........606 Riker Bldg., Pontiac 48058

OCEANA COUNTY MEDICAL SOCIETY (178)

Barker, V. D................22 N. State St., Hart 49420
Davis, Linford J............22 N. State St., Hart, 49420
Gerig, Dean O. (O)............218 N. Michigan Ave., Shelby 49455
Hasty, Willis A...........204 N. Michigan, Shelby 49455
Johnson, C. A...................Box 6, New Era 49446
Mullen, Warren R....................Pentwater 49449
Robinson, Wm. G. (A)..............Memorial Hospital, Fatehgarh, U. P., India
Vrbanac, John J.............22 N. State St., Hart 49420
Wood, Merle G. (R)..........19 Courtland, Hart 49420

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H.........Box 223, Ontonagon 49953
Hill, Karl E...........9 Hemlock St., White Pine 49971
Lahti, Carl R....................R. 2, Ontonagon 49953
Pierpont, John............141 Maple, White Pine 49971
Strong, James P.........R. 1, Box 406, Ontonagon 49953

OTTAWA COUNTY MEDICAL SOCIETY (186)

Albers, Robt..............601 Michigan, Holland 49423
Arendshorst, Wm.......601 Michigan Ave., Holland 49423
Beernink, Ernest H. (L).................Duncan Ct., Grand Haven 49417
Bloemendaal, Dirk C. (L)...351 N. Main, Zeeland 49464
Bloemendal, W. B. (A)................411 Woodlawn, Grand Haven 49417
Boersma, Vernon L........121 W. 24th St., Holland 49423
Bonzelaar, Alvin..........144 West 26th, Holland 49423
Bradford, Phillip............87 W. 24th, Holland 49423
Bulthuis, Jerry E......................Jamestown 49427
Chamness, James K.....121 W. 24th Street, Holland 49423
Clark, Nelson H...........17 W. 10th St., Holland 49423
Cook, Carl S............121 W. 24th St., Holland 49423
DeCook, Joseph L..........1021 Central, Holland 49423
Devalois, Bernadine.....766 W. 24th St., Holland 49423
De Vries, Harold G.........30 E. 9th St., Holland 49423
De Vries, Peter J....321 Washington, Grand Haven 49417
De Witt, Donald E.......390 Fairhill Dr., Holland 49423
De Young, Fredk. W.................Spring Lake 49456
Dood, Arnold R.........598 Central Ave., Holland 49423
Dykema, Paul........788 Columbia Ave., Holland 49423
Dykstra, Jerome H..........601 Michigan, Holland 49423
Endean, Donald H......121 West 24th St., Holland 49423
Frieswyk, Melvin J.......241 E. Main St., Zeeland 49464
Gesink, Owen J.........492 Orchard Hill, Holland 49423
Groat, Frank L.....631 Franklin St., Grand Haven, 49417
Hager, Ralph........................Hudsonville 49426
Hamelink, Marinus H.....700 W. 26th St., Holland 49423
Harms, Herman P.........17 W. 10th St., Holland 49423
Heard, Wm. (R)........504 Park St., Grand Haven 49417
Helbing, Edw. J., Jr.....17 W. 10th Street, Holland 49423
Henderson, Jack A...............1310 Wisconsin Ave., Grand Haven 49417
Hommerson, H. J.............3559 M40, Hamilton 49419
Kearney, Jos. B..........121 W. 24th St., Holland 49423
Kemme, Gerrit J................R. No. 3, Zeeland 49464
Kitchel, John H......414 Franklin St., Grand Haven 49417
Kitchel, Mary F. S.....P.O. Box 521, Grand Haven 49417
Kools, Wm. C. (L)......194 W. 11th St., Holland 49423
Korpi, Steven......520 Ottawa Ave., Grand Haven 49417
Kuipers, Siebe W.......391 W. 31st Street, Holland 49423
Leppink, Richard A.........601 Michigan, Holland 49423
Mahaney, Robert C....601 Michigan Ave., Holland 49423
McArthur, Peter A...1310 Wisconsin, Grand Haven 49417
Meeuwsen, Bernard....601 Michigan Ave., Holland 49423
Moerdyk, Wm. J. (L)....120 W. 14th St., Holland 49423
Nykamp, Russel R........111 E. Main St., Zeeland 49464
Parker, Phillip L......1181 Univista Dr., Holland 49423
Post, J. Jay..........................Allendale 49401
Rottschaefer, Wm..........601 Michigan, Holland 49423
Rotz, Lloyd........575 Robbins Rd., Grand Haven 49417
Rypkema, Willard M...............22 South 2nd Street, Grand Haven 49417
Schaftenaar, R. H..........86 E. 28th St., Holland 49423
Schmidt, Frederick (M)...................6 Hancock, Ft. Leavenworth, Ks. 66027
Sikkema, Donald E..1310 Wisconsin, Grand Haven 49417
Smit, George J.........601 Michigan Ave., Holland 49423
Stobbelaar, Robt. H...1310 Wisconsin, Grand Haven 49417
Ten Have, Ralph (L)..1030 Orchard, Grand Haven 49417
Ten Pas, Henry W........293 W. 29th St., Holland 49423
Timmerman, Eugene C..............Coopersville 49404
Vander Berg, Edwin E.....17 W. 10th St., Holland 49423

Van Der Velde, Otto (L)...33 W. 8th St., Holland 49423
Vande Waa, Alfred J.....152 E. Cherry St., Zeeland 49464
Van Kolken, P. J........509 Franklin, Grand Haven 49417
Van Krimpen, Carl E...601 Michigan Ave., Holland 49423
Veenstra, Bernard M.................Grand Haven 49417
Ver Duin, John W...1618 Gladys Ave., Grand Haven 49417
Verkaik, Peter.........................Hudsonville 49426
Wang, Charles........14 East 25th Street, Holland 49423
Wassink, Jerome H...........34 E. 33rd., Holland 49423
Wells, Kenneth N...119 W. Savidge St., Spring Lake 49456
Westrate, Warren K........17 W. 10th St., Holland 49423
Westrate, Wm., Sr. (L)....17 W. 10th St., Holland 49423
Westrate, Wm., Jr..........17 W. 10th St., Holland 49423
Winter, John K.............726 State St., Holland 49423
Winter, Wm. G., Jr..........630 State St., Holland 49423
Yff, John H............430 W. Lawrence, Zeeland 49464
Yonkman, Fredk. F...58 Pomeroy Rd., Madison, N.J. 07940
Zanstra, Benjamin (O)............3337 Van Buren St., Hudsonville 49426

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L. (R)..........124 S. Jefferson Ave., Saginaw 48607
Albers, Millard J...1227 N. Michigan Ave., Saginaw 48602
Anderson, Wm. K. (L)............845 St. Andrews Rd., Saginaw 48603
App, Robt. G............3422 Davenport, Saginaw 48602
Arnas, George C...1600 N. Michigan Ave., Saginaw 48602
Averill, Walter C...........2110 Morson, Saginaw 48602
Balcueua, Edgar P........2 Chippewa Ct., Saginaw 48602
Barry, Jack L...........5670 Dixie Hwy., Saginaw 48601
Barry, Leroy C...........705 Adams St., Saginaw 48602
Bass, Vernon V..........3322 Davenport, Saginaw 48602
Behme, C. Peter.........5160 Helga Dr., Saginaw 48603
Bellinger, Don H. DDS (A)..............P.O. Box 365, Nakomis, Florida 33555
Bergeon, Michael T..........2115 Bay St., Saginaw 48602
Bertrand, Marc G...1311 N. Michigan Ave., Saginaw 48602
Bishop, Harry M. (R)....P.O. Box 129, Harrisville 48740
Bitner, Leland M...1811 N. Michigan Ave., Saginaw 48607
Blanchard, Gerald E.....GMC Chev. Mtr. Div., Box 1749, Saginaw 48605
Bow, William A.........4987 State Street, Saginaw 48603
Bradley, Edward............4444 State Rd., Apt. 214E, Saginaw 48603
Brender, Friedrich P................Frankenmuth 48734
Briggs, Gordon......350 W. Washington, Hemlock 48626
Bruggers, Laurence 1703 N. Michigan Ave., Saginaw 48602
Bullington, Bert M........2000 Court St., Saginaw 48602
Burnett, Quinter M.........4385 Concord, Saginaw 48603
Busch, Frank J......1731 N. Michigan St., Saginaw 48602
Butler, Milton G...1600 N. Michigan Ave., Saginaw 48602
Cady, Donald J...........2002 Court St., Saginaw 48602
Cady, Fredk. J., Jr...402 S. Jefferson Ave., Saginaw 48607
Cady, Fredk. J. (L)..402 S. Jefferson Ave., Saginaw 48607
Cambridge, V. W......Potter at Jefferson, Saginaw 48607
Cameron, Allan K...1314 S. Jefferson Ave., Saginaw 48601
Campbell, Lloyd A. (R)..............335 Brockway Pl., Saginaw 48602
Caumartin, Hugh T..........1537 S. Washington Ave., Saginaw 48601
Chisena, Peter R...........6221 Dixie, Bridgeport 48722
Clowater, Robert A.............Saginaw County Hosp., Saginaw 48605
Cortopassi, Vital E.............324 S. Washington Ave., Saginaw 48607
Cory, Chas W.........1227 N. Michigan, Saginaw 48602
Cresswell, T. A........1236 N. Michigan, Saginaw 48602
Cullen, Geo. (A)....2529 N. Clinton St., Saginaw 48602
Curts, James H.....1205 N. Michigan Ave., Saginaw 48602
Davenport, Clyde P.........2110 Morson, Saginaw 48602
Derifield, R. S. (A).......25 Bretton Ct., Saginaw 48602
DeYoung, William A...............Central Laboratories, 1100 S. Washington, Saginaw 48601
Dowidat, Raymond W. (A)..608 Westfield, Saginaw 48602
Durman, Donald C. (R)...740 Belair Dr., Saginaw 48603
Ellis, George A........16 E. Hannum Blvd., Saginaw 48602
Ely, Cecil W............1820 Janes Ave., Saginaw 48601
Ernst, Arthur R. (R)....Fieldmont, The Plains, Va. 22171
Farley, Albert W.........1013 N. Michigan, Saginaw 48602
Field, E. Malcolm.....1013 N. Michigan, Saginaw 48602
Finger, John E........29 Brian Scott Place, Saginaw 48602
Fleschner, Thos. E. (R)..7749 Marlette, Birch Run 48415
Forster, Kenneth J.........27 Benton Rd., Saginaw 48602
Galsterer, Edwin C...124 S. Jefferson Ave., Saginaw 48607
Gamon, Adam E., II......2004 Court St., Saginaw 48602
Gardner, Joe H.....815 N. Michigan Ave., Saginaw 48602
Gerard, Roy J...........2419 Mackinaw, Saginaw 48602
Gilmore, Robt. D.........234 W. Saginaw, Merrill 48637
Goldner, Richard D.....1024 N. Michigan, Saginaw 48602
Gomon, Louis D...1203 N. Michigan Ave., Saginaw 48602
Goodsell, John O.......1600 N. Michigan, Saginaw 48602
Goodsell, J. Orton, DDS (A)......1305 S. Ocean Blvd., Box 2854, Pompano Beach, Fla. 33062
Goodwin, J. E..1600 N. Mich. Ave., #301, Saginaw 48602
Grant, Michael............101 Marcy, St. Charles 48655
Grundy, Betty Lou....4725 Century Dr., Saginaw 48603
Gugino, George J...........1941 Gate St., Reese 48757
Hand, Eugene A......126 N. Franklin St., Saginaw 48607
Harris, Geo. P.....Saginaw General Hosp., Saginaw 48602
Harvie, Lloyd C. (L)..........330 S. Washington Ave., Saginaw 48607
Hausler, Richard C......206 S. Webster, Saginaw 48602
Heavenrich, Robt. M....1107 Gratiot Ave., Saginaw 48602
Heilbronn, Duane B....1703 N. Michigan, Saginaw 48602
Heinmiller, E. C...Saginaw Gen. Hospital, Saginaw 48605
Helmkamp, Herbert O.....333 S. Jefferson, Saginaw 48607
Hereza, Valeriano D......2125 Bay Street, Saginaw 48602
Herlihy, Mary.............101 Marcy, St. Charles 48655
Heuschele, Richard P...1909 Coolidge St., Saginaw 48603
Hill, Victor, Jr.....1703 N. Michigan Ave., Saginaw 48602
Hines, Ronald G......St. Marys Hospital, Saginaw 48605
Hoban, Sean J. (A)..............1232 N. Michigan Ave., Saginaw 48602
Hubinger, H. L., D.D.S. (A)...501 2nd Natl. Bnk. Bldg., Saginaw
Hunt, Maurice E........5000 Maple St., Fairgrove 48733
Hyslop, Wm. T.........1610 Gratiot Ave., Saginaw 48602
Iizuka, Reiichi............69 Benton Rd., Saginaw 48602
Infante, A..............1931 E. Genesee, Saginaw 48601
James, John W.......1021 W. Genesee St., Saginaw 48607
Jardinico, Robert........3 Center Woods, Saginaw 48603
Jarvi, Rudolph M.......1107 Gratiot Ave., Saginaw 48602
Johnson, G. T. (A)........V.A. Hospital, Saginaw
Johnstone, Kermit T.....1050 Fisher Dr., Saginaw 48601
Jordan, Leo A........1524 E. Genesee St., Saginaw 48607
Kelly, Michael V...1811 N. Michigan Ave., Saginaw 48602
Kerr, Wm. B.........300 S. Michigan St., Saginaw 48602
Kershul, Victor W...............314 Graebner Bldg., 120 N. Michigan Ave., Saginaw 48602
Keyes, James T.......10222 Maple Rd., Birch Run 48415
Kickham, Edward F.......705 Adams St., Saginaw 48602
Kleekamp, Herbert G. (R)......1776 S. Rogers Rd., R. 1, Clare 48617
Kleinschmidt, Earl E.....3625 Webber St., Saginaw 48601
Kolesar, Robt. C............1005 Gratiot, Saginaw 48602
Koucky, Charles J.......14 Center Woods, Saginaw 48603
Kowals, Francis V. (R)......Med. Dir. Chec. Ser. G.M.C., Saginaw 48603
Kretschmer, Thos. V.............1232 N. Michigan Ave., Saginaw 48602
Labsan, H. F......1803 N. Michigan Ave., Saginaw 48602
Lassignal, Jules C...1600 N. Michigan Ave., Saginaw 48602
Lepperd, F. C., Jr. (A)....1500 Weiss St., Saginaw 48602
Lian, Teck S...........518 Eleanor Ave., Saginaw 48602
Ling, Kenneth C.........................Hemlock 48626
Loftin, Robert L.......1501 N. Michigan, Saginaw 48602
Lohr, Thos. O.....1135 N. Michigan Ave., Saginaw 48602
Love, Neil W.......505 W. Tuscola, Frankenmuth 48734
Lurie, Robt. I...2525 S. Washington Ave., Saginaw 48601
Mahaney, Thos. P.......3521 State Street, Saginaw 48602
Manning, John E...815 N. Michigan Ave., Saginaw 48602
Manning, John W., III........705 Adams, Saginaw 48602

Markey, Francis L......1600 N. Michigan, Saginaw 48602
Martin, Jack F.....1011 N. Michigan Ave., Saginaw 48602
Martzowka, Wm. P....415 W. Genesee St., Saginaw 48602
Mason, Wm. G.........1107 Gratiot Ave., Saginaw 48602
Matthews, Harry C..............1227 N. Michigan Ave., Saginaw 48602
Mayne, Harold E......2111 Marshall Ct., Saginaw 48602
McEwen, Wm. G..........1502 Court St., Saginaw 48602
Meyer, Henry J. (L)..6243 Dixie Hwy., Bridgeport 48722
Mikan, V. Robert......3900 Holland Rd., Saginaw 48601
Miller, Glenn F...........2224 Mershon, Saginaw 48602
Moeser, Ulrich.........1447 N. Harrison, Saginaw 48602
Moon, A. Raymond (L)..705 Sunset Lane, Cadillac 49601
Mooney, James C...1600 N. Michigan Ave., Saginaw 48602
Morgrette, Leonard J.....3424 Davenport, Saginaw 48602
Mudd, Richard D. (R)....1001 Hoyt St., Saginaw 48607
Mulhern, Donal T...2716 S. Jefferson Ave., Saginaw 48607
Murphy, Albert P...303 N. Michigan Ave., Saginaw 48602
Murphy, Richard T., D.D.S. (A)......1718 N. Michigan, Saginaw 48602
Murray, Morris J.........3424 Davenport, Saginaw 48602
Nelson, Oscar A.........3324 Davenport, Saginaw 48602
Nese, T. S...............830 S. Jefferson, Saginaw 48601
Noble, Paul R..........1447 N. Harrison, Saginaw 48602
Northway, Robt. O.....1811 N. Michigan, Saginaw 48602
Novy, Frank O. (L)..420 S. Jefferson Ave., Saginaw 48607
Obregon, Carlos......2805 Germain Dr., Saginaw 48601
Olson, Carl P. (A)................122 Morningside Dr., Battle Creek 49015
Packer, James E...........5230 State St., Saginaw 48603
Patrick, Susan J...........715 Fifth St., Baldwin 49304
Perea, Manuel M........599 N. Frost Dr., Saginaw 48603
Phillips, Homer A......1600 N. Michigan, Saginaw 48602
Powers, Robt. F........1600 N. Michigan, Saginaw 48602
Prather, Perry E......1227 N. Mich. Ave., Saginaw 48602
Prinsell, Gustave G. (M).........Houghton, N.Y. 14774
Rank, J. Eugene.......1107 Gratiot Ave., Saginaw 48602
Reichman, Jos. J...........1455 Sheffield, Saginaw 48605
Reimers, Gerald F.......4046 Hess Street, Saginaw 48601
Rice, William T....1827 N. Michigan Ave., Saginaw 48602
Richards, Ned W..........3518 State St., Saginaw 48602
Richter, Harry J. (R)..1401 W. Delta Dr., Saginaw 48603
Roggen, Ivan J.........1227 N. Michigan, Saginaw 48602
Ruskin, Dave B.........1600 N. Michigan, Saginaw 48602
Ryan, Richard S...1581 S. Washington Ave., Saginaw 48601
Sargent, Donald V. 1703 N. Michigan Ave., Saginaw 48602
Sarmiento, G. A...1600 N. Michigan Ave., Saginaw 48602
Schneider, A. J. N....509 S. Jefferson Ave., Saginaw 48607
Schultz, Frank R......243 W. Broad St., Chesaning 48616
Scott, Gerard..........5670 Dixie Hwy., Saginaw 48601
Sharp, Martin C...1803 N. Michigan Ave., Saginaw 48602
Shek, John L...........803 N. Michigan, Saginaw 48602
Sheldon, Suel A. (L).....124 S. Jefferson, Saginaw 48607
Sherman, John W.........403 S. Fayette, Saginaw 48602
Simms, Uca Frances......5707 Evergreen, Midland 48640
Skowronski, C. A.....1401 E. Genesee St., Saginaw 48607
Slade, Homer G....1520 N. Michigan Ave., Saginaw 48602
Spengler, Donald E., D.D.S. (A)......4481 Bradford Dr., Saginaw 48603
Stander, Aaron C..........1411 Court St., Saginaw 48602
Sulfridge, Hugh L., Jr...........1011 N. Michigan Ave., Saginaw 48602
Talbot, Joseph E...1311 N. Michigan Ave., Saginaw 48602
Taylor, Robert E.......1447 N. Harrison, Saginaw 48602
Thompson, Arthur B......2144 Ottawa St., Saginaw 48602
Tiedke, Gunther E...120 N. Michigan Ave., Saginaw 48602
Toteff, Robert J............2110 Morson, Saginaw 48602
Tramitz, Melvin E......711 Somerset Rd., Saginaw 48603
Tuttle, Terence K.........1109 Court St., Saginaw 48602
Underhill, Wm. G...........8 Five Oaks, Saginaw 48603
Villegas, Alfonso A...1232 N. Mich. Ave., Saginaw 48602
Vincent, John H......4158 Atwood Ln., Bridgeport 48722
Vitu, Robert L..........703 W. Genesee, Saginaw 48602
Volk, Vladimir K. (L)........Saginaw Co. Hosp., Box 65, Saginaw 48605
Waite, Barry F............403 S. Fayette, Saginaw 48602
Walsh, Peter R...........331 S. Jefferson, Saginaw 48607
Webb, Lester E............1500 Gratiot, Saginaw 48602
Weiss, Arno W...........3521 State St., Saginaw 48602
Westlund, Norman........3253 Congress, Saginaw 48602
Woomer, Donald F..............1227 N. Michigan Ave., Saginaw 48602
Wright, Edwin M......1311 N. Michigan, Saginaw 48602
Yntema, Stuart (L)........51 Davis Dr., Saginaw 48602
Young, John.............705 Cooper St., Saginaw 48602

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S.......2425 Military St., Port Huron 48060
Balboa, Ronaldo S.......St. Clair Clinic, St. Clair 48079
Banting, Kenneth C.............403 Peoples Bk. Bldg., Port Huron 48060
Barss, J. A............1209 Tenth St., Port Huron 48060
Battley, John C. S. (L)..1216 6th St., Port Huron 48060
Beck, Frank K..........2902 Military, Port Huron 48060
Beer, Jos. F.......104 N. Riverside Ave., Saint Clair 48079
Bennett, Wm. G.............210 S. Main St., Yale 48097
Blatter, Erwin W.....3864 Gratiot Ave., Port Huron 48060
Borden, Chas. L.......236 Huron Ave., Port Huron 48060
Bottomley, Thos. H., Jr...1102 Sixth St., Port Huron 48060
Boughner, Walter H......325 Pleasant St., Algonac 48001
Bovee, Marion E. (L)..2208 Stone St., Port Huron 48060
Bowden, Wm. S......130 Washington, Marine City 48039
Bridge, Ezra V.......416 Edison Blvd., Port Huron 48060
Burke, Colman J.......................311 Pine St., Port Huron 48060
Candler, Clarence L. (L)..815 Brown St., St. Clair 48079
Cantwell, John D., Jr.....2425 Military, Port Huron 48060
Chafty, Mahmoud.......2425 Military, Port Huron 48060
Cleland, Wm. D., Jr. Medical Arts Bldg., Port Huron 48060
Clifford, Robt. P.....506 S. Riverside Dr., St. Clair 48079
Clyne, Benj. C..............103 N. Main St., Yale 48097
Coury, John J., Jr.......1209 Tenth St., Port Huron 48060
Davison, Wm. T......2425 Military St., Port Huron 48060
Dinnen, Wm. J., Jr........2425 Military, Port Huron 48060
Douvas, Nicholas G........4200 Gratiot, Port Huron 48060
Dupuis, Jean Paul.....1502 Shumaker, Port Huron 48060
Escalera, Gustavo (A)..........1605 Fred Moore Hwy., St. Clair 48079
Fenton, Edwin H...906 St. Clair River Rd., Algonac 48001
Fitzgerald, E. W., Jr.....1102 Sixth St., Port Huron 48060
Franke, Armin T........2425 Military, Port Huron 48060
Fuerst, Erwin J.......1322 N. River Rd., St. Clair 48079
Fulton, Harold E., Jr...2425 Military St., Port Huron 48060
Gerrits, James F..........St. Clair Clinic, St. Clair 48079
Gholz, Anthony C...Medical Arts Bldg., Port Huron 48060
Gilmore, John R...317 Mich. Bank Bldg., Port Huron 48060
Gonzalez, Carlos F.....1605 Division Rd., St. Clair 48079
Hazledine, H. J.....4685 Lakeshore Rd., Port Huron 48060
Hislop, David M. C...............5076 Lake Shore Rd., Port Huron 48060
Hlivko, Alexander E..........1605 Fred W. Moore Hwy., St. Clair 48079
Hodgins, Thomas E. (A)..............3540 Lapeer Ave., Port Huron 48060
Holcomb, Russell J......140 S. Market, Marine City 48039
Hoyt, Chas. N.........1501 Krafft Rd., Port Huron 48060
Johnston, Thomas C...2425 Military St., Port Huron 48060
Kahn, Oscar B..........................Capac, 48014
Kirban, Harry N...5500 Lakeshore Rd., Port Huron 48060
Kirker, J. G. (L)...626 Busha Highway, Marysville 48040
Koch, Donald A.......2425 Military St., Port Huron 48060
Kostoff, Harold R.......310 Water St., Port Huron 48060
Lauridsen, James........621 River St., Port Huron 48060
Le Galley, K. B. (A)............6942 E. Exeter Blvd., Scottsdale, Az. 85251
Licker, Reuben R.....2425 Military St., Port Huron 48060
Ludwig, Claude A.....916 Seventh St., Port Huron 48060
Ludwig, Fredk. E........916 7th St., Port Huron 48060
Lugg, Robt. M...........619 River St., Port Huron 48060
Mayhew, Harry E....613 N. Riverside Dr., St. Clair 48079
Meza, Pedro........1105 Sedgwick St., Port Huron 48060
Miller, John M......1010 Griswold St., Port Huron 48060
Mohney, Glenn E........1131 Erie St., Port Huron 48060

Morris, Alvin N.........621 River St., Port Huron 48060
Neruda, Fred..........640 N. Third St., St. Clair 48079
Novak, Walter S.....310 E. Water St., Port Huron 48060
Olivera, Juan E.....2425 Military St., Port Huron 48060
Patterson, Dorsey W. (L).............622 Huron Ave., Port Huron 48060
Raftery, Michael.......2425 Military, Port Huron 48060
Relken, Richard C...2920 Pine Grove, Port Huron 48060
Rowe, Robt. E....108 McMorran Blvd., Port Huron 48060
Rutledge, John J. (A).............2205 Standish Court, Port Huron 48060
Sabbagh, Michael I..........1605 Fred W. Moore Hwy., St. Clair 48079
Sanderson, Jos. L.........515 Pine St., Port Huron 48060
Schaefer, Waldo A...............302 Mich. Bank Bldg., Port Huron 48060
Serniak, John A.............104 S. Main St., Yale 48097
Sharpe, James W....310 E. Water St., Port Huron 48060
Shoudy, Elmore D.....902 Tenth Ave., Port Huron 48060
Snider, James J.........2425 Military, Port Huron 48060
Tisdel, James H......310 E. Water St., Port Huron 48060
Tomsu, Glenn F.......310 E. Water St., Port Huron 48060
Townley, Chas. O......1209 Tenth St., Port Huron 48060
Treadgold, Douglas (A)..............1323 Military St., Port Huron 48060
Ulmer, Arthur H., Jr....1209 Tenth St., Port Huron 48060
Walker, Sidney C......1209 Tenth St., Port Huron 48060
Ware, J. Raleigh (R)....3107 24th St., Port Huron 48060
Webb, Gordon H......1322 N. River Rd., St. Clair 48079
Weckesser, W. C........1602 Military, Port Huron 48060
Wilhelm, Daniel J.....619 River Street, Port Huron 48060
Yost, Kenneth W.....1305 Gratiot Ave., Marysville 48040
Youngs, John A. .....718 Griswold St., Port Huron, 48060
Yull, Arthur B.........1209 Tenth St., Port Huron 48060

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A......106 E. Chicago Rd., Sturgis 49091
Bradley, D. E..............234 S. Main St., Colon 49040
Braham, Wilbur G.........111 S. Monroe, Sturgis 49091
Brothers, Paul L....1313 Rolling Ridge Ln., Sturgis 49091
Brunson, Allen E..........206 E. West St., Sturgis 49091
Dettman, Harold.........Maplecrest Plaza, Sturgis 49091
Evans, Robt. H..........111 S. Monroe St., Sturgis 49091
Fiegel, S. Albert...........111 S. Monroe, Sturgis 49091
Fortner, Roscoe J....137 Portage Ave., Three Rivers 49093
Gillespie, Eleanor M. (A)..........173 Waban Hill Rd., Newton, Ma. 02167
Hill, Robert V...............1500 N. Main St., Box 171, Three Rivers 49093
Jacobowitz, John M..................Lincoln at Millard, Three Rivers 49093
Lepard, Olin L........Knollwood Dr., R. 1, Sturgis 49091
Lewis, Robert........104 S. Lakeview St., Sturgis 49091
McCullough, Hugh......111 S. Monroe St., Sturgis 49091
O'Dell, Charles W.....117 Spring St., Three Rivers 49093
O'Dell, John H., Jr..................Three Rivers 49093
Olney, Frank (A)....................Centerville 49032
Pennington, Harry C.................118 S. Kalamazoo, White Pigeon 49099
Penzotti, Stanley C.....117 Spring St., Three Rivers 49093
Porter, Clark G..........226 East St., Three Rivers 49093
Schimnoski, D. R..............Three Rivers Med. Clnc., Three Rivers 49093
Shaw, Geo. D.........117 Spring St., Three Rivers 49093
Sheldon, John P...........206 E. West St., Sturgis 49091
Smith, Robt. D............................Colon 49040
Weisheit, H. R....................Route 1, Sturgis 49091
Zimont, Chas. R......................Constantine 49042
Zimont, Raymond D.................Constantine 49042

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R........................Marlette 48453
Duvall, Dorothy......817 Patterson Ave., Bay City 48706
Ellis, Larry G.........426 W. Speaker, Sandusky 48471
Ford, Frances A. (L)...........2683 S. Lakeshore Rd., Applegate 48401
Gariepy, Bernard F..................Deckerville 48427
Gift, Weldon A. (L)....................Marlette 48453
Groat, Gerald.........................Deckerville 48427
Hart, Robt. K. (L)....................Croswell 48422
Jayson, Michael H......2764 Lorraine St., Marlette 48453
McCrea, John W.......................Marlette 48453
McGunegle, Keate T....................Sandusky 48471
Muir, Neil............................Croswell 48422
Seager, M. Cole........................Brown City 48416
Smith, Duane E.......................Brown City 48416
Tweedie, G. Evans.....................Sandusky 48471
Tweedie, S. Martin....................Sandusky 48471
Webster, J. C. (L)....................Marlette 48453
Winfield, Raymond J........3014 Main St., Marlette 48453

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L., Jr. (L).............R. 1, Ovid 48866
Austin, Eugene S............1260 Ada St., Owosso 48867
Bach, Norman F..........113 E. Williams, Owosso 48867
Bjarnesen, Walter (A)...............7518 Hamlet St., North Springfield, Va. 22151
Brown, Richard C.....113 E. Williams St., Owosso 48867
Buzzard, Walter D.....................Chesaning 48616
Cameron, Richard R...........San Antonio State Hosp., 5900 South Presa, San Antonio, Tx. 78223
Chapman, Daniel....825 Packard Rd., Ann Arbor 48104
Chipman, Elwood M. (R).........502 W. Williams St., Owosso 48867
Clifford, Robert..........Matthews Bldg., Owosso 48867
Foerster, Alfred W....113 E. Williams St., Owosso 48867
Ford, Wm. J. A., Jr....113 E. Williams St., Owosso 48867
Forsyth, Henry T.....137 S. Saginaw St., Chesaning 48616
Graves, James H.........511 W. Main St., Owosso 48867
Gurden, Elizabeth A. L.............113 E. Williams St., Owosso 48867
Harroun, John E...........323 N. Ball St., Owosso 48867
Harroun, R. V.............323 N. Ball St., Owosso 48867
Hofstra, John..........................Owosso 48867
Hoshal, Verne L..........104 W. Clinton, Durand 48429
Kennedy, John J........1626 N. Chipman, Owosso 48867
Lipsey, Donald..........................Durand 48429
MacGregor, John F.....113 E. Williams St., Owosso 48867
McGeehan, J. S...........Matthews Bldg., Owosso 48867
McKnight, Edwin R..............320 N. Washington St., Owosso 48867
Merz, Walter L...............307 N. Ball, Owosso 48867
Moore, Phillip J..........221 E. North St., Owosso 48867
Morovitz, John E.........113 E. Williams, Owosso 48867
Park, James H............812 Bradley St., Owosso 48867
Phillips, Rolland..........Matthews Bldg., Owosso 48867
Richards, Chester J. (L) 101 E. Monroe St., Durand 48429
Roty, Robert L. (M)......Matthews Bldg., Owosso 48867
Sahlmark, Jos. F..........812 Bradley St., Owosso 48867
Sauer, Peter.............113 E. Williams, Owosso 48867
Shepherd, Walter F. (R)......Box 148, Coldwater 49036
Trick, O. L. (A)...Duke University, Durham, N.C. 27706
Weinkauf, Wm. F. (L)................Corunna 48817
Weston, Claude L. (L)....Matthews Bldg., Owosso 48867
Wickstrom, Geo. B.........529 Clark Ave., Owosso 48867
Yun, Bo Sup..............826 W. King, Owosso 48867

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Anderson, Norma.............206 Ellington, Caro 48723
Ballard, James H......................Cass City 48726
Chapin, Maurice H..................Millington 48746
Cole, Versa V................Lock Box A, Caro 48723
Dickerson, Willard W. (R)..Caro State Hosp., Caro 48723
Donahue, Harold T........4674 Hill St., Cass City 48726
Elmendorf, E. N., II.....................Vassar 48768
Flett, Richard O......................Millington 48746
Gokcora, Nurettin B..........Caro St. Hosp., Caro 48723
Howlett, Robt. R.....................Star Rte. 221A, McMasters Bridge Rd., Grayling 49738
Kovacs, Geza.............861 Gilford Road, Caro 48723
Merrill, Elmer H............506 Gilford Rd., Caro 48723
Miles, Edward J...........................Caro 48723
Nigg, Herbert L..........................Caro 48723
Savage, Lloyd L. (L).............5208 Port Austin Rd., Caseville 48725
Schurter, Bettye S. C.......Caro State Hosp., Caro 48723
Swanson, Ewald C............220 N. Main, Vassar 48768
Urban, Mitchell...........Caro State Hosp., Caro 48723
Von Renner, Otto (L)........P.O. Box 396, Reese 48757

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F.......................Hartford 49057
Boothby, Fredk. M....................Lawrence 49064
Boyd, Wayne R........Route 4, Box 307, Paw Paw 49079
Cooper, Jos. E.........417 W. Monroe St., Bangor 49013
Davis, James M........424 Huron St., South Haven 49090
Diephuis, Bert........511 Huron St., South Haven 49090
Dillon, Thos. J. (A)....240 S. Eudora, Denver, Co. 80220
Gano, Avison.............417 Monroe St., Bangor 49013
Itzen, John F..........P.O. Box 485, South Haven 49090
Kleber, John A........365 Broadway, South Haven 49090
Lawther, John............P.O. Box 191, Hartford 49057
Loomis, Frank J.......................Paw Paw 49079
Lukaszek, Henry J. 77 N. Shore Drive, South Haven 49090
McFadden, Roscoe I.................RFD #1, Box 83, Bloomingdale 49026
Millard, David.......................Paw Paw 49079
Morgan, Dale K......403 Phoenix St., South Haven 49090
Parks, Arthur E.......................Lawton 49065
Spalding, R. W..............P.O. Box 280, Gobles 49055
Stagg, Adelbert L.........9 N. Maple St., Hartford 49057
Stagg, G. Lee.................Box 307, Hartford 49057
Stagg, Ruth E. A................Box 38, Hartford 49057
Sundin, Paul W. (A)......106 E. First St., Monroe 48161
Ten Houten, Charles..................Paw Paw 49079
Terwilliger, Edwin H...P.O. Box 110, South Haven 49090
Urist, Martin J.............Route 5, South Haven 49090
Witte, David B.............Route 3, South Haven 49090
Young, Wm. R. (L)....................Lawton 49065

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Abell, Murray R..1335 E. Catherine St., Ann Arbor 48104
Alexander, Don K.....301 N. Ingalls St., Ann Arbor 48104
Alford, Barry H.............385 N. Mill, Plymouth 48170
Allen, Richard J.....University Hospital, Ann Arbor 48104
Allis, Lyle M...2355 E. Stadium Blvd., Ann Arbor 48104
Anderson, David G........2490 Adare, Ann Arbor 48104
Anderson, Gerhard D. (A).........9500 E. Orchard Dr., Englewood, Co. 80110
Anderson, Robt. E.....2136 S. Seventh, Ann Arbor 48103
Apostolakis, J. L. (A)..............Dept. of Radiology, University Hospital, Ann Arbor 48104
Atchison, Russell M.....501 W. Dunlap, Northville 48167
Ause, Robert G..........1821 Sheridan, Ann Arbor 48104
Badgley, Carl E. (L).....2100 Hill St., Ann Arbor 48104
Bailey, Robt. W.......University Hosp., Ann Arbor 48104
Baird, Walter M...2558 Old Boston Ct., Ann Arbor 48104
Baker, Dale E..St. Joseph Mercy Hosp., Ann Arbor 48104
Bandera, Emily A.......P.O. Box 1047, Ann Arbor 48106
Bandera, Jaroslav M...........4200 E. Huron River Dr., Ann Arbor 48104
Banghart, Norman L...............1950 Manchester Rd., Ann Arbor 48104
Barker, Paul S. (R)......Box 87, Bonnots Mill, Mo. 65016
Barlow, R. Craig.....326 N. Ingalls St., Ann Arbor 48104
Barron, Walter L.......2201 Delaware, Ann Arbor 48103
Barry, Alexander, Ph.D. (A)....Med. Sc. Bldg., U. of M., Ann Arbor 48104
Barss, Wm. A...........525 W. Cross St., Ypsilanti 48197
Bartholomew, Lee E...........4633 Kresge Bldg., U. M., Ann Arbor 48104
Bass, Thos. J............201 S. Hamilton, Ypsilanti 48197
Bassow, Paul H........St. Joseph Hosp., Ann Arbor 48104
Bauer, Gerhard H...2015 Manchester Rd., Ann Arbor 48104
Bauer, Jere M.........1313 E. Ann St., Ann Arbor 48104
Behrman, Saml.....2866 Provincial Dr., Ann Arbor 48104
Beierwaltes, Wm. H..............U. M. Medical Center, Ann Arbor 48104
Beison, Richard A....1795 W. Stadium, Ann Arbor 48103
Bell, Margaret (L)...............1107 E. Adelaide Dr., Tucson, Az. 85719
Belser, Walter...2310 E. Stadium Blvd., Ann Arbor 48104
Bender, Leonard F.....1313 E. Ann St., Ann Arbor 48104
Benson, Paul J., Jr...227 N. Sheldon Rd., Plymouth 48170
Benson, Ronald M. (A)...........1053 Island Drive Ct., Ann Arbor 48105
Bentley, Fredk. E.......851 S. Main St., Plymouth 48170
Bicknell, John N...703 First Natl. Bldg., Ann Arbor
Blair, Albert J., Jr......1739 Sheridan, Ann Arbor 48104
Boblitt, Delbert E.....2112 Wallingford, Ann Arbor 48104
Bogard, William J. (A)..........Box A, Ypsilanti 48197
Boles, Roger............4785 Lake Ct., Ann Arbor 48103
Borocz, Istvan (M)..USAF Hosp., Wright Patterson AFB, Dayton, Oh. 45433
Bosch, Jan K...........302 W. Main St., Northville 48167
Botch, Edmund S................2310 E. Stadium Blvd., Ann Arbor 48104
Botsford, James H.........775 S. Main St., Chelsea 48118
Boudeman, John E. (A)........St. Joseph Mercy Hosp., Ann Arbor 48104
Bourne, Charles W. (M)..............208 E. Wisconsin, Milwaukee, Wi. 53202
Brandl, Earl A.......Hydromatic Division, Ypsilanti 48197
Brandt, Ralph L.........326 N. Ingalls, Ann Arbor 48104
Breakey, Barry A........2216 Medford, Ann Arbor 48104
Brewer, Wilson K. (R) 4255 Washtenaw, Ann Arbor 48104
Britt, Eugene M., Ph.D. (A)........1411 Bardstown Tr., Ann Arbor 48105
Brougher, Robert H................1100 W. Huron St., Ann Arbor 48103
Brovins, Walter G...Ypsilanti State Hosp., Ypsilanti 48197
Brown, Philip N. (R)...1403 Division Dr., Milford 48042
Brown, Wm. E., III..2101 Belmont Rd., Ann Arbor 48104
Bryan, George C..........2547 Ellis Rd., Ypsilanti 48197
Bryant, H. C.......425 E. Washington, Ann Arbor 48108
Bucalo, Harry D., Jr....2207 S. Seventh, Ann Arbor 48103
Buchanan, Robert A.....2715 Brockman, Ann Arbor 48104
Burke, Dennis R.........125 Harper Drive, Saline 48176
Bush, Jack L.....1950 Manchester Rd., Ann Arbor 48104
Butler, Gerald E...2311 E. Stadium Blvd., Ann Arbor 48104
Cameron, George H....2311 E. Stadium, Ann Arbor 48104
Cameron, Hugh A...............425 E. Washington St., Ann Arbor 48108
Campbell, Darrell A.......617 Stratford, Ann Arbor 48104
Candell, Antimo.......2318 Medford, Ann Arbor 48104
Canty, Charles (A)....2347 Yost Blvd., Ann Arbor 48104
Capili, A. M..........14 N. Hamilton St., Ypsilanti 48197

Capili, E. Esquejo.....14 N. Hamilton St., Ypsilanti 48197
Carbeck, Robt. B.........3080 Exmoor, Ann Arbor 48104
Carroll, Catherine........1130 Hill St., Ann Arbor 48104
Carron, Dean P.....425 E. Washington, Ann Arbor 48108
Carter, Thomas L. (A)..........2131 Georgetown Blvd., Ann Arbor 48105
Cassidy, James T.........590 Lansway, Ann Arbor 48103
Cerny, Joseph C...University Med. Ctr., Ann Arbor 48104
Chatas, George J....2984 Hickory Lane, Ann Arbor 48104
Chesky, Robert H.....1130 Hill Street, Ann Arbor 48104
Child, Chas. G., III. .University Hospital, Ann Arbor 48104
Claeys, Eugene F...........775 S. Main, Chelsea 48118
Clague, Allan G.....1743 Waltham Dr., Ann Arbor 48103
Clifford, Mary Ellen. .University Hospital, Ann Arbor 48104
Clyde, Ensign E.......1181 S. Main St., Plymouth 48170
Coe, Robert O. (A)..University Hosp., Ann Arbor 48104
Cohan, Bruce E...2355 E. Stadium Blvd., Ann Arbor 48104
Conn, Jerome W...200 Orchard Hill Dr., Ann Arbor 48104
Copping, James W., Jr. (A)...........2757 Canterbury, Ann Arbor 48104
Courtney, Kenneth O.....2119 Melrose, Ann Arbor 48104
Courtney, N. Warn (A)........823rd Med. Group, AFB, Homestead, Florida 33030
Cox, Morton S., Jr.....70 E. Waters Rd., Ann Arbor 48103
Crook, Clarence E.............1050 Wall St., Apt. 10A, Ann Arbor 48105
Cross, Thomas N...Univ. Medical Center, Ann Arbor 48104
Curtis, Arthur C. (L)..1313 E. Ann St., Ann Arbor 48104
Curtis, Edward G................1825 W. Stadium Blvd., Ann Arbor 48103
Davenport, Charles W...........2311 E. Stadium Blvd., Ann Arbor 48104
Davenport, Fred M.....1038 Martin Pl., Ann Arbor 48104
Davey, Paula G.....425 E. Washington, Ann Arbor 48108
Davey, Winthrop N........495 Hillspur, Ann Arbor 48105
Deatrick, Richard W................2940 Hickory Lane, Ann Arbor 48104
de Caires, Percy F. R.....700 Avon Rd., Ann Arbor 48104
De Jong, Russell N...1526 Harding Rd., Ann Arbor 48104
Dekornfeld, Thomas J.............2581 Hawthorn Rd., Ann Arbor 48104
Dell, Thomas A.......2900 Brandywine, Ann Arbor 48104
Delong, Wm. B. (M)...USAF Hospital, Tachikawa, Japan
Demuth, George R......Univ. Hospital, Ann Arbor 48104
Den Houter, W. D.......225 N. Sheldon, Plymouth 48170
De Tar, John S. (L)........55 W. Main St., Milan 48160
Dew, Richard C. 2355 E. Stadium Blvd., Ann Arbor 48104
Diaz Perez, Rodrigo......2939 Renfrew, Ann Arbor
Didelius, D. P. Lt. MC (M)
Dieterich, Gordon C...4038 Jackson Rd., Ann Arbor 48106
Dillman, Richard S......1800 Baldwin, Ann Arbor 48104
Dingman, Reed O.......221 N. Ingalls, Ann Arbor 48104
Dinman, Bertram D...1132 Aberdeen Dr., Ann Arbor 48104
Dodson, Vernon N...............1638 University Hosp., Ann Arbor 48104
Doezema, Edward R. 1111 E. Catherine, Ann Arbor 48104
Dolfin, Wilbur E.........2210 Melrose, Ann Arbor 48104
Domino, Edward F.......3071 Exmoor, Ann Arbor 48104
Dorr, Richard P. (A)..............University Hospital, Ann Arbor 48104
Douthat, Rudenz T.....1415 Beechwood, Ann Arbor 48103
Draper, Bruce........2222 Fuller Rd., Ann Arbor 48105
Driver, James R.......155 Underdown, Ann Arbor 48105
Dryer, Clyde K...........3033 Sophia St., Wayne 48184
Dukay, Alexander P......3501 Willis Rd., Ypsilanti 48197
Edmunds, Wm. P.........21 S. Prospect, Ypsilanti 48197
Edwards, Melvin L., Jr. 1210 Maple Rd., Ann Arbor 48103
Eliot, Johan W.....Sch. of Pub. Health, Ann Arbor 48104
Elliott, Lyle D............27 S. Prospect, Ypsilanti 48197
Emmert, Gregor K. (A)....Urology Dept., Univ. Hosp., Ann Arbor 48104
Engelke, Otto K. (L).........313 Washtenaw Co. Bldg., Ann Arbor 48108
Epstein, Jerome L.......27 S. Prospect, Ypsilanti 48197
Fajans. Stefan S.......2485 Devonshire, Ann Arbor 48104
Falk, Elwin C...........14 N. Hamilton, Ypsilanti 48197
Falls, Harold F........University Hosp., Ann Arbor 48104
Farhat, Saeed M..........424 Onaway, Ann Arbor 48104
Fayos, Juan V...University Med. Center, Ann Arbor 48104
Feller, Irving.........2023 Devonshire, Ann Arbor 48104
Fellman, S. L.......2216 Medford Rd., Ann Arbor 48104
Ferrington, R. A...........519 W. Main St., Milan 48160
Finch, Jay S.....51259 Murray Hill Dr., Plymouth 48170
Finch, Stuart M. Child Psychiatric Hosp., Ann Arbor 48104
Fink, Geo. C..........411 Linda Vista, Ann Arbor 48104
Fink, George H. (A)....459 Manor Dr., Ann Arbor 48105
Fischmann, George. .1321 Franklin Blvd., Ann Arbor 48103
Fisher, Jos. V...............116 Park St., Chelsea 48118
Fisher, Robert J........21 S. Prospect St., Ypsilanti 48197
Foley, Arthur Lee, II...........2001 Brampton Court A, Ann Arbor 48103
Ford, Jack (M) ....#402, Fort Sanders Prof. Bldg., Knoxville, Tenn. 37916
Fox, Winslow G......715 N. University, Ann Arbor 48104
Fralick, F. Bruce..............D-2137, N. Out Patient, University Hosp., Ann Arbor 48104
Francis, Thos., Jr..............U. Mich. Schl. Pub. Hlth., Ann Arbor 48104
Fransway, Robt. L................2785 Park Ridge Dr., Ann Arbor 48103
French, Arthur B...1405 E. Ann St., W 4642 Univ. Hosp., Ann Arbor 48104
French, A. James....356 Ausable Place, Ann Arbor 48104
Frey, Charles F...3555 Daleview Dr., Ann Arbor 48103
Frohlich, Moses M.....1313 E. Ann St., Ann Arbor 48104
Frost, Lyle W.....309 N. Washington St., Ypsilanti 48197
Frye, Carl M...........301 N. Ingalls, Ann Arbor 48104
Furstenberg, A. C. (L)..............2240 Belmont Rd., Ann Arbor 48104
Gabrielsen, T. O....................Dept. of Radiology, University Med. Center, Ann Arbor 48103
Gall, John C.......2903 Sheffield Ct., Ann Arbor 48105
Garrison, D. E. Lt. MCUSN (M)....117 Buckingham Pl., Brunswick, Ga. 31520
Gates, George A.....3689 Frederick Dr., Ann Arbor 48105
Gerigk, Paul F............250 E. Michigan, Saline 48176
Getting, Vlado A...........Sch. of Pub. Hlth., U. of M., Ann Arbor 48104
Gignac, Ralph M.........32320 Michigan, Wayne 48184
Gikas, Paul W..........1900 Mershon, Ann Arbor 48103
Ging, Rosalie J....Veterans Adm. Hosp., Ann Arbor 48105
Goldsmith, Robt. I..............216 Mich. Theatre Bldg., Ann Arbor 48106
Gonzalez-Videla, F. E. (A)............3501 Willis Rd., Ypsilanti 48197
Gosling, John R. G.....315 Corrie Rd., Ann Arbor 48105
Gottlieb, Joel D.......1800 Traver Rd., Ann Arbor 48105
Gotz, Alexander.....2201 Medford Rd., Ann Arbor 48104
Gould, Stuart M., Jr...........Mercywood Hosp., Box 65, Ann Arbor 48107
Grabb, William C. 325 Barton Shore Dr., Ann Arbor 48105
Gracie, Wm. A., Jr....2441 Shannondale, Ann Arbor 48104
Graves, Wm. H., III....2760 Provincial, Ann Arbor 48104
Gray, Jerry M.................St. Joseph Mercy Hosp., Ann Arbor 48104
Greene, James A., Jr.............251 Orchard Hills Dr., Ann Arbor 48104
Grillo, S. Phillip...........265 Main St., Belleville 48111
Gros, Gerard...........1025 Berkshire, Ann Arbor 48104
Gutierrez, Norma B................Ypsilanti State Hosp., Ypsilanti 48197
Habel, Dan W. (M)..S 1708 Maple, Spokane, Wa. 99203
Hagerman, Geo. W...321 N. Ingalls St., Ann Arbor 48104
Haig, Owen G. (A)..2803 Towner Blvd., Ann Arbor 48104
Haight, Cameron......1313 E. Ann St., Ann Arbor 48104
Hammond, Walter W., Jr...........221 N. Sheldon Rd., Plymouth 48170
Handorf, H. H. (L)....455 Park Place, Northville 48167
Hankamp, Lamar J.....2119 Woodside, Ann Arbor 48104
Hannum, Marvin R...........54 W. Main, Milan 48160
Hanson, Frederick N...............34178 Spring Valley, Westland 48185
Harrell, E. R., Jr................Univ. Med. Ctr., Rm. C, Ann Arbor 48104
Harris, Bradley M. (L)....27 S. Prospect, Ypsilanti 48197
Harris, Scott T.......44490 Clare Blvd., Plymouth 48170
Hartman, Robt. T............519 W. Main, Milan 48160
Hein, Gerhardt A. (A)...1121 Granger, Ann Arbor 48104
Henderson, John W....University Hosp., Ann Arbor 48104
Hendrix, Robt. C.....1139 Vesper Rd., Ann Arbor 48103
Henry, L. Dell (L)..706 W. Huron St., Ann Arbor 48103
Herbertson, F. James (A) 2381 Pinecrest, Ann Arbor 48104

Heston, Wm. M., III. .720 E. Catherine, Ann Arbor 48104
Hickok, David K. (M). .2526 Kalarama Rd., Portage 49081
Hicks, Samuel P. . . . .1112 Meadowbrook, Ann Arbor 48103
Hildebrandt, H. Mark. . . . .1130 Hill St., Ann Arbor 48104
Hinerman, Dorin L. . . . .1313 E. Ann St., Ann Arbor 48104
Hing, Ng Harry. . . .1323 Franklin Blvd., Ann Arbor 48103
Hiraga, Mikio H. . . . . .1795 W. Stadium, Ann Arbor 48103
Hodges, Fred J. (L). . . .5 Highland Ln., Ann Arbor 48104
Holmes, Donald J. . . . . .505 Barton North Dr., Ann Arbor 48105
Holt, John F. . . . . .1313 E. Ann St., Ann Arbor 48104
Holtz, Fred. . . . . .326 N. Ingalls, Ann Arbor 48104
Hoskins, Phillip A. . . .824 Edgewood Pl., Ann Arbor 48103
House, Frederic B. . . . . .1240 Crosby Crescent, Ann Arbor 48103
Howard, Stacy C. (R) . . . . .1936 Whitehall, Winter Park, Fla. 32789
Howatt, William F. . .University Hospital, Ann Arbor 48104
Hubbard, Wm. N., Jr. . . . . .Univ. of Mich. Med. Sch., Ann Arbor 48104
Huizenga, Philip B. . . . . .Box A, Ypsilanti 48197
Hulett, Ralph M. . . . .2881 Provincial Dr., Ann Arbor 48104
Hull, Ralph F. (A). .Univ. Medical Ctr., Ann Arbor 48104
Hyman, Saml. J. . . . . . .27342 Michigan Ave., Inkster 48141
Ideson, Robt. S., II. . . .2200 Vinewood, Ann Arbor 48104
Jackson, Joseph E. . . . .2220 Page Ave., Ann Arbor 48104
Jacob, Jos. S. . . . .202 E. Washington St., Ann Arbor 48108
Jaffe, Burton (M). .1245 Creal Crescent, Ann Arbor 48103
Jeffries, Frank W. 425 E. Washington St., Ann Arbor 48108
Jender, Joseph G. . . . .1302 W. Maple St., Plymouth 48170
Jimenez, B. (R) . . . . .215 A S. Main St., Ann Arbor 48108
Johnson, Paul S. (A). .3007 Geddes Ave., Ann Arbor 48104
Johnson, Robt. D. . . . .3432 Woodlea Dr., Ann Arbor 48103
Johnston, Franklin D. . . . . .University Hospital, Ann Arbor 48104
Joseph, Sydney. .2311 E. Stadium Blvd., Ann Arbor 48104
Judge, Richard D. . Univ. Medical Center, Ann Arbor 48104
Julian, Mark D. . . . . .740 S. Emerick, Ypsilanti 48197
Kahn, Edgar A. . . . . .500 Burson Pl., Ann Arbor 48104
Kambly, Arnold H., Jr. . 201 S. Main St., Ann Arbor 48108
Kaufer, Herbert. . . . .Univ. Medical Ctr., Ann Arbor 48104
Kaump, Donald H. . . . . . .P.O. Box 1047, Ann Arbor 48106
Keary, Frank V. (A) . . . . .25 Carstead Dr., Slingerlands, N.Y. 12159
Keaton, Alan L. (A). . .2410 Walter Dr., Ann Arbor 48103
Kelley, Jack L. (M) . . . . .4513 1 O'Donnell Hts., Ft. Riley, Ks. 66442
Kelley, Paul A. . . . . .326 N. Ingalls, Ann Arbor 48104
Kem, David C. (M). . . .U. S. Army, Tripler Gen. Hosp., APO San Francisco, Ca. 96438
Kemph, John P. . . . . .521 Hillspur, Ann Arbor 48105
Kerlikowske, A. C. . . . .1313 E. Ann St., Ann Arbor 48104
Kern, Wheeler H. 2011 Middlebelt Rd., Garden City 48135
Kerry, Robert L. . . . . . .2695 Appleway, Ann Arbor 48104
Kheder, Jamil. . . . . .44526 Clare Blvd., Plymouth 48170
Kimbrough, Wm. W. . .1231 Ferdon Rd., Ann Arbor 48104
Kittleson, Arthur C. 2111 Devonshire Rd., Ann Arbor 48104
Kivi, Louis P. . . . . .5950 W. Textile Rd., Saline 48176
Klein, Edward W. . . . . .St. Joseph Mercy Hosp., Ann Arbor 48104
Knoll, Leo A. (R) . . . . .2002 Scottwood, Ann Arbor 48104
Koepke, Geo. H. . . . .University Hospital, Ann Arbor 48104
Komar, Norman N. (A) . . . . .1605 Argyle Crescent, Ann Arbor 48103
Konzen, Jon L. (A) . . . . . . .7625 Second St., Dexter 48130
Kooi, Kenneth A. . . . .2132 Needham Rd., Ann Arbor 48104
Kraft, Richard O. 2355 E. Stadium Blvd., Ann Arbor 48104
Krausse, Chas. F. . . . . .116 Park St., Chelsea 48118
Krickstein, Herbert. . . . . .564 Glen Arbor Ln., Grosse Pte. Woods 48236
Krigbaum, Edmund M. . . . . .3075 Overridge Dr., Ann Arbor 48104
Kumasaka, Glen H. . . . .1411 Harbrooke, Ann Arbor 48103
Kwass, Stephen K. (M) . . . . .U. S. Naval Hosp., Bethesda, Maryland 20014
Lampe, Isadore. . . . . . . .1313 E. Ann St., Ann Arbor 48104
Lane, Alexander Z. . . . . .5732 Pierson Rd., Fayetteville, N.Y. 13066
Lapides, Jack. . . . . .University Hospital, Ann Arbor 48104
Law, John L. (R). .1116 41st Ave. E., Seattle, Wa. 98102

Lease, Glenn O. . .3460 Cottontail Lane, Ann Arbor 48103
Lee, Fred. . . . . .1926 Day St., Ann Arbor 48104
Lindenauer, S. M. . .2711 Antietam Court, Ann Arbor 48105
Locken, Gail Ann. .8255 W. Huron River Dr., Dexter 48130
Lockett, Harold J. . . . .319 Brookside Dr., Ann Arbor 48105
Lovell, Robert G. . . . . .326 N. Ingalls St., Ann Arbor 48104
Lowrey, Geo. H. . . . . . .University Hosp., Ann Arbor 48104
Lowry, Claud M. . . . .1707 Shadford Rd., Ann Arbor 48104
Lucas, Alexander R. . . . . .951 E. Lafayette, Detroit 48207
Magee, Kenneth R. . . . .1313 E. Ann St., Ann Arbor 48104
Magielski, John E. . . . . .2355 Londonderry Rd., Ann Arbor 48104
Magnuson, Harold J. . . . . .1634 Univ. Medical Ctr., Ann Arbor 48104
Magoon, Duncan J. J. . . . .225 E. Liberty, Ann Arbor 48108
Malcolm, Karl D. . . . .311 N. Ingalls St., Ann Arbor 48104
Maley, John E. . . . .5441 Walsh Rd., Whitmore Lake 48189
Margolis, Philip M. . . . . .725 City Center Bldg., Ann Arbor 48108
Markel, Sheldon F. . . . . .St. Joseph Mercy Hosp., Ann Arbor 48104
Markham, Thomas N. (A) . . . . .2645 Scio Church Rd., Ann Arbor 48103
Marshall, Mark (L) . . . .1803 South Blvd., Ann Arbor 48104
Martel, William. . . . . . . .2972 Parkridge, Ann Arbor 48103
Martin, Donald W. . .5 North Hamilton St., Ypsilanti 48197
Mason, Joyce W. . . . . . .1908 Scottwood, Ann Arbor 48104
Mason, Stephen C., III. . . . . .820 E. University, Ann Arbor 48104
Mathews, Kenneth P. . . . . .1145 Aberdeen Dr., Ann Arbor 48104
Mavis, Nancy Ann (A) . . . . .Radiology Dept., U of M Hospital, Ann Arbor 48104
McCubbrey, David R. . . . . .221 N. Sheldon Rd., Plymouth 48170
McDermott, J. F., Jr. . . . . . .525 Hillspur, Ann Arbor 48105
McEachern, Thos. H. . . . . . .1130 Hill St., Ann Arbor 48104
McLean, James A. . . . . . .1313 E. Ann St., Ann Arbor 48104
McPhee, Malcolm (A). .1245 Island Dr., Ann Arbor 48105
McWilliams, John R. . . . .201 S. Main St., Ann Arbor 48108
Meadows, Joseph M., Jr. . . . . .2685 Overridge Dr., Ann Arbor 48104
Meeks, Louis W. (A) . . . . . . .9 Lois Ct., Ann Arbor 48103
Meriney, David K. (A) . . . . .University Hospital, Ann Arbor 48104
Michaels, Alvin B. (A) . . . . . .18777 W. Ten Mile Road, Southfield 48075
Middleton, David H. . . . . .Univ. of Mich. Med. Ctr., Ann Arbor 48104
Miedler, Leo J. . . . . .3100 W. Central, Toledo, Ohio 43606
Milford, A. F., Jr. . .419 W. Michigan Ave., Ypsilanti 48197
Miller, Ira I. . . . . . .1718 Hermitage Rd., Ann Arbor 48104
Miller, Norman F. (L). .R. 2, Box 390, Florence Wi. 54121
Miskovsky, Thomas J. (A) . . . . . .4714 70th Ave., CTW, Tacoma, Wash. 98466
Morley, Geo. W. . . . . . .University Hosp., Ann Arbor 48104
Morris, Joe D. . . . . .1313 E. Ann St., Ann Arbor 48104
Mostaghim, Amir M. . . . . .2005 Roosevelt, Ypsilanti 48197
Moyad, Robert H. . . . . .303 Pearl St., Ypsilanti 48197
Moyyad, John. . . . . . . .740 S. Emerick St., Ypsilanti 48197
Murray, Wm. A. . . . .1705 Covington Dr., Ann Arbor 48103
Myers, James W. (A) . . . . .St. Joseph Mercy Hosp., Ann Arbor 48104
Neely, Jo Ann (A) . . .Radiology Dept., U of M Hospital, Ann Arbor 48104
Nelson, Roger B. . . . . . .1313 E. Ann St., Ann Arbor 48104
Nesbit, Reed M. (L) . . . . .U. of M. Med. Ctr., #303, Ann Arbor 48104
Newton, Chas. W., Jr. . . . . .2310 E. Stadium Blvd., Ann Arbor 48104
Nichols, Richard D. (A). .1822 Pontiac, Ann Arbor 48105
Nickhah, Fazlolah A. . . . . . .1320 Ellis Rd., Ypsilanti 48197
Nishiyama, R. H. . . . . . .2305 Vinewood, Ann Arbor 48104
Nixon, John C. . .2144 Georgetown Blvd., Ann Arbor 48105
Nobel, Rudolph E. . . . . .612 S. Forest, Ann Arbor 48104
O'Connor, Gerald A. . . . . .U. of M. Medical Ctr., Ann Arbor 48104
O'Connor, Patricia. . . . . .2120 Medford, Apt. 4, Ann Arbor 48104
Ohmart, Bruce R. (M). .2150 Iroquois Ave., Detroit 48214
Olariu, John. . . . . .Box A, Ypsilanti 48197

Olsen, William R.....6 Buckingham Ct., Ann Arbor 48104
Olson, Nels R.......2950 Newport Rd., Ann Arbor 48103
O'Neal, Robert M.....221 N. Ingalls St., Ann Arbor 48104
Orwig, James B. (A)................2812 Tucker Lane, Rossmoor, Ca. 90720
Ostrander, L. D., Jr...............2793 Manchester Rd., Ann Arbor 48104
Pahucki, Gena R.......317 S. State St., Ann Arbor 48108
Palmer, Algernon A. (L)............110 E. Middle St., Chelsea 48118
Panahi, Parviz...2355 E. Stadium Blvd., Ann Arbor 48104
Papo, Michael...........775 S. Main St., Chelsea 48118
Parker, Walter G. (A).343 S. Main St., Ann Arbor 48104
Pasley, Francis C...18471 Haggerty Rd., Northville 48167
Pasricha, Satya P...Ypsilanti State Hosp., Ypsilanti 48197
Payne, Beverly C. 425 E. Washington St., Ann Arbor 48108
Pearson, Delbert E....4660 Washtenaw, Ann Arbor 48104
Pearson, Marlin J...2541 Devonshire Rd., Ann Arbor
Perlman, Jack M.....2664 Antietam Ct., Ann Arbor 48105
Peterson, Thomas R...............2015 Manchester Rd., Ann Arbor 48104
Petropoulos, Gust C.......1415 Roosevelt, Ypsilanti 48197
Pfister, Roswell R. (A)..............Univ. Medical Ctr., Ann Arbor 48104
Pfrender, Richard E. (M)........Madigan General Hosp., Tacoma, Wa. 98431
Pierce, Edward C.....1795 W. Stadium, Ann Arbor 48103
Place, Edwin H. (R) 2616 Hawthorn Rd., Ann Arbor 48104
Pollard, H. Marvin...............2012 Vinewood Blvd., Ann Arbor 48104
Pollard, John C...............3240 W. Huron River Dr., Ann Arbor 48103
Portney, Gerald L. (M)............PHS Indian Hospital, Dept. HEW, Fort Defiance, Ariz. 86504
Postmus, Roger W.....662 Wembley Ct., Ann Arbor 48103
Potter, Marcia L.........318 W. Cross St., Ypsilanti 48197
Powsner, Rhoda M.....2200 Fuller Rd., Ann Arbor 48105
Preuss, Lawrence.......916 Northwood, Ann Arbor 48103
Prout, Gordon J.............401 Mills Rd., Saline 48176
Quiroz, Hugo......26585 13 Mile Road, Franklin 48025
Rae, James W., Jr.....1313 E. Ann St., Ann Arbor 48104
Ransom, Henry K. (L).721 South Forest, Ann Arbor 48104
Raphael, Theophile (L)...430 Hillspur, Ann Arbor 48105
Rapp, Robert....1460 Cedar Bend Dr., Ann Arbor 48105
Ratliff, Rigdon K.....326 N. Ingalls St., Ann Arbor 48104
Regan, Wm. J., Jr.......326 N. Ingalls, Ann Arbor 48104
Rehner, Robt. C...2378 E. Stadium Blvd., Ann Arbor 48104
Reichert, Rudolph E., Jr...1046 Baldwin, Ann Arbor 48104
Reinhart, Melvin J....1921 Hampton Ct., Ann Arbor 48103
Rekshan, Wm. R.....47558 N. Shore Dr., Belleville 48111
Renfrew, Murray S. (A)....311 Gralake, Ann Arbor 48103
Rich, Elizabeth J................Pedlar Mills, Va. 24574
Richards, Kathryn E. (A).............812 Kuebler Dr., Ann Arbor 48103
Riker, Donald D.........706 W. Huron, Ann Arbor 48103
Ritter, Frank N.......2675 Englave Dr., Ann Arbor 48103
Robey, Ames..............Box 2060, Ann Arbor 48104
Robinson, Orlo J., Jr.......501 Dunlap, Northville 48167
Robinson, Wm. D.....1405 E. Ann St., Ann Arbor 48104
Ross, C. Howard (L)...........715 N. University Ave., Ann Arbor 48104
Rucknagel, Donald L..............1615 Saunders Cres., Ann Arbor 48103
Russo, Sam F.......9551 Main St., Whitmore Lake 48189
Sandall, Gary S. (A)..611 Church St., Ann Arbor 48104
Saunders, Allen..2361 E. Stadium Blvd., Ann Arbor 48104
Sayre, Geo. S.............27 S. Prospect, Ypsilanti 48197
Schaefer, Donald L.....201 E. Liberty, Ann Arbor 48108
Schmidt, C. M.......941 Newport Rd., Ann Arbor 48103
Schmidt, David W...1230 N. Maple Rd., Ann Arbor 48103
Schneider, Richard C........1313 E. Ann St., Dept. N. S., Ann Arbor 48104
Schoch, Henry K.....Vets. Admin. Hosp., Ann Arbor 48105
Schumacher, Wm. E. (L)........303 1st National Bldg., Ann Arbor
Schunk, Herbert..425 E. Washington St., Ann Arbor 48108
Schwartz, S. A., Capt. MC (M)......20th Station Hosp., APO New York 09696
Scovill, Henry A.......1313 W. Cross St., Ypsilanti 48197
Seevers, Maurice H...............740 Spring Valley Dr., Ann Arbor 48105
Segat, Maria Z...455 Huntington Drive, Ann Arbor 48104
Selzer, Melvin L.....1201 Red Oak Rd., Ann Arbor 48103
Shadoan, James D.....314 Washington St., Chelsea 48118
Shafii, Mohammad (A).........Childrens Psych. Hosp., Ann Arbor 48104
Shammas, Jules...........2260 Prairie, Ann Arbor 48105
Sharbrough, F. W., III (M)............107 Bridget Ct., San Antonio, Tx. 78236
Shearer, M. L., Jr.............8044 Dexter Pinckney Rd., Dexter 48130
Shearer, M. R.......8044 Dexter Pinckney, Dexter 48130
Shelton, John C..............105 Ferris, Ypsilanti 48197
Sheperdigian, A. A. (A)............9841 Hamburg Rd., Brighton 48116
Shervington, W. W. (A)..2794 Page St., Ann Arbor 48104
Shoecraft, Harriet L. 425 E. Washington, Ann Arbor 48108
Sigler, Louis E., Jr...1443 Covington Dr., Ann Arbor 48103
Simpson, John F...1723 Ivywood Drive, Ann Arbor 48103
Simpson, L. R., Capt. MC (M)............112 Childress, Sheppard AFB, Tx. 76311
Sirola, Olga..........1710 Collegewood, Ypsilanti 48197
Sisson, James C.....2665 Balmoral Ct., Ann Arbor 48103
Sitterley, Brooks H. (A)..........1209 Roosevelt Blvd., Ypsilanti 48197
Slee, Vergil N.........201 S. Main St., Ann Arbor 48108
Sloan, David B., Jr. (M)......U.S. Naval Hosp., FPO, San Francisco, Calif. 96630
Sloan, J. Bernard (A)..USAF Hosp., Scott AFB, Il. 62225
Smillie, John W.......1335 Fairlane Dr., Ann Arbor 48104
Smith, Donald C..............326 Victor Baughn Bldg., Ann Arbor
Smith, Edward B...University Hospital, Ann Arbor 48104
Smith, Edwin M........1815 Arbordale, Ann Arbor 48103
Smith, Eleanor...425 E. Washington St., Ann Arbor 48108
Smith, Russell F.....9569 Main St., Whitmore Lake 48189
Smith, William S..............C4202 Univer. Med. Ctr., Ann Arbor 48104
Sonnega, James.......Hawthorn Center, Northville 48167
Stetten, Maynard L. (M).................407 Scotty, San Antonio, Tx. 78227
Steude, Georgine M....1450 Bardstown, Ann Arbor 48105
Stevens, Tatjana (A)..30838 Barrington Dr., Wayne 48184
Stilp, Lyall C., II (A)....1525 Marion, Ann Arbor 48103
Stimson, Cyrus W...1706 Shadford Rd., Ann Arbor 48104
Stoker, Gerald L....326 N. Ingalls St., Ann Arbor 48104
Strang, Ruth H...............4500 E. Huron River Dr., Ann Arbor 48104
Straschnov, Geo. J.....1678, Merriman Rd., Wayne 48184
Struthers, James N. P............Box A, 3501 Willis Rd., Ypsilanti 48197
Stubbs, Bruce T..........775 S. Main St., Chelsea 48118
Sunderhause, Earl E. (A)..............1086 Island Dr., Ann Arbor 48105
Sweet, Robt. B........1313 E. Ann St., Ann Arbor 48104
Taylor, Fulton B..........1341 Jay Ave., Ypsilanti 48197
Taylor, Wm. B..........326 N. Ingalls, Ann Arbor 48104
Teed, R. Wallace..........215 S. Main, Ann Arbor 48108
Thieme, E. Thurston...........St. Joseph Mercy Hosp., Ann Arbor 48104
Thompson, A. S.....2432 Dorchester Rd., Ann Arbor 48104
Thompson, George R...............2656 Parkridge Dr., Ann Arbor 48103
Threatt, Barbara A. (A).............44652 Ecorse Rd., Belleville 48111
Tipton, John B.........2646 Craig Rd., Ann Arbor 48103
Tiziani, Joseph J.............3412 Brassow, Saline 48176
Tourtellotte, W. W.....University Hosp., Ann Arbor 48104
Towsley, Harry A...W-5610 Univ. Hosp., Ann Arbor 48104
Turcotte, J. G.........769 Heatherway, Ann Arbor 48104
Vander Yacht, W. C.........203 Russell St., Saline 48176
Van Duzen, Verne L. (L)....131 E. Miller, Milan 48160
Vanhouten, Wiecher H...............Univ. Medical Ctr., Ann Arbor 48104
Van Reesema, F. S.....1608 Kirtland Dr., Ann Arbor 48103
Vanselow, Neal A.......1532 Warwick, Ann Arbor 48104
Waggoner, R. Walter..3333 Geddes Rd., Ann Arbor 48105
Waggoner, R. W., Jr. (A) 1421 Barnard, Ann Arbor 48103
Waldron, Alexander M...309 N. Ingalls, Ann Arbor 48104
Waldyke, Jerry L.........775 S. Main St., Chelsea 48118
Wallner, Julius M......1313 E. Ann St., Ann Arbor 48104
Wamsteker, E. F...3415 Robinwood Dr., Ann Arbor 48103

Watkins, Richard D........4140 Miller, Ann Arbor 48103
Watson, Ernest H. University Med. Cen., Ann Arbor 48104
Wegman, Myron E................University of Michigan, Ann Arbor 48104
Weisman, Raoul L.....32 N. Washington, Ypsilanti 48197
Weiss, Chas. F..............Box 1047, Ann Arbor 48106
Weller, John M...2508 Londonderry Rd., Ann Arbor 48104
Westcott, Geo. W......511 W. Michigan, Ypsilanti 48197
Westerberg, Martha R...1313 E. Ann St., Ann Arbor 48104
Westover, Chas J...............982 W. Ann Arbor Trail, Plymouth 48170
Wetterstroem, Robt. G...........46376 W. 7 Mile Road., Northville 48167
Whale, Edmund H.....207 Fletcher Ave., Ann Arbor 48104
White, Richard L.....740 Wagner Rd., Ann Arbor 48103
Whitehouse, W. M...1313 E. Ann Street, Ann Arbor 48104
Whowell, Marianne..1805 Ivywood Dr., Ann Arbor 48103
Wicht, Paul J.............27 S. Prospect, Ypsilanti 48197
Williams, Howard R................1950 Manchester Rd., Ann Arbor 48104
Williamson, Fredk. B.............319 W. Michigan Ave., Ypsilanti 48197
Willis, Park W., III..University Hospital, Ann Arbor 48104
Willson, J. Robert...Univ. Med. Center, Ann Arbor 48104
Wilson, J. LeRoy (L)..1313 E. Ann St., Ann Arbor 48104
Winkler, James M......3 Regent Court, Ann Arbor 48104
Wischman, Charles L. (M)............353 Fulton Street, Seattle, Wa. 98109
Wolter, J. Reimer..............University Med. Center, Ann Arbor 48104
Woodburne, R. T., Ph.D. (A)......2520 Hawthorne Rd., Ann Arbor 48104
Woods, Scott W..........27 S. Prospect, Ypsilanti 48197
Work, Walter P...University Med. Cent., Ann Arbor 48104
Worth, Melissa H. C. (L)............3211 Packard Rd., Ann Arbor 48104
Wright, Harold L........18741 Haggerty, Northville 48167
Wyman, John S.....2224 Highland Rd., Ann Arbor 48104
Yaroch, William C....2200 Fuller Rd., Ann Arbor 48105
Yelin, Frank S. (A)..............Texas Medical Center, Div. of Neurosurgery, Houston, Texas 77025
Yoder, Orus R. (L)..700 Cambridge Rd., Ypsilanti 48197
Zarafonetis, C. J. D.............Simpson Memorial Inst., Ann Arbor 48106
Zerbi, Victor M...........27 S. Prospect, Ypsilanti 48197
Zrull, Joel P............630 Dartmoor, Ann Arbor 48103

WEXFORD-MISSAUKEE COUNTY MEDICAL SOCIETY (226)

Anderson, R. E............615 Oak Street, Cadillac 49601
Barnett, Robert F.........Mercy Hospital, Cadillac 49601
Bentley, M. D...............828 Oak St., Cadillac 49601
Cannon, John P......107½ N. Mitchell St., Cadillac 49601
Cardinal, Thos H..........212 S. Simons, Cadillac 49601
Daugharty, Robt. V.......107 N. Mitchell, Cadillac 49601
Garber, Lawrence O......222 Howard St., Cadillac 49601
Inman, John C.......................Lake City 49651
Kleyn, Kenneth A...105½ N. Mitchell St., Cadillac 49601
Pierce, Robert E......1430 Sunnyside Dr., Cadillac 49601
Posthuma, Millard...........828 Oak St., Cadillac 49601
Richmond, Thomas F...604 Lake Shore Dr., Cadillac 49601
Sanderson, James M..........512 Chapin, Cadillac 49601
Seger, Dean W.......................Lake City 49651
Tyrrell, Carleton F. (O)................Manton 49663
Van Alst, Dennis E..........828 Oak St., Cadillac 49601
Youngman, Douglas C....................Marion 49665

WAYNE COUNTY MEDICAL SOCIETY (222)

Abbassian, A.............3815 Pelham, Dearborn 48124
Abbott, James A.........1012 Kales Bldg., Detroit 48226
Aben, Gerald J.....15901 W. 9 Mile Rd., Southfield 48075
Ablao, Arsenio B. (A)...........Northville State Hosp., Northville 48167
Aboassaly, Michel...1059 Bedford, Grosse Pte. Park 48236
Aboulafia, Elie D.........18241 Greenfield, Detroit 48235
Abraham, Jos. P......2799 W. Grand Blvd., Detroit 48202
Acosta, Julio B...........25447 Plymouth, Detroit 48239
Adamian, Gerald D...............15901 W. 9 Mile Rd., Southfield 48075
Adams, James R. (A)......3815 Pelham, Dearborn 48124
Adams, Vincent B.....19641 Mack Ave., Grosse Pte. 48236
Adamski, Arthur.........19600 Van Dyke, Detroit 48234
Adelson, Irwin P. (A)..Detroit Psych. Inst., Detroit 48202
Adelson, Sidney L.......16221 Schoolcraft, Detroit 48227
Adler, Morton W..............2860 Clark, Detroit 48232
Adler, Sidney........3011 W. Grand Blvd., Detroit 48202
Agah, Manoochehr..........Wayne County Hlth. Dept., Merriman Rd., Eloise 48132
Agnew, Geo. H......3011 W. Grand Blvd., Detroit 48202
Agnew, Richard C. (M)..564 Fisher Bldg., Detroit 48202
Agnone, Eugene J.....1420 St. Antoine St., Detroit 48226
Agnone, Peter M......1420 St. Antoine St., Detroit 48226
Aiuto, Jas. J.........660 Cadieux Rd., Grosse Pte. 48230
Ajlouni, Issa S.............Chrysler Corp., Detroit 48226
Ajluni, Roger M.....33521 W. 6 Mile Rd., Livonia 48152
Akroyd, Cecil..........16551 W. Warren, Detroit 48228
Alban, Emil J., Jr.......7940 Allen Rd., Allen Park 48101
Albrecht, Albert J.........4407 Roemer, Dearborn 48126
Alcantara, Elsa A...........9801 Conant, Detroit 48212
Alcantara, Lucilo C.........9801 Conant, Detroit 48212
Alexander, Allen...........18881 Hilton, Southfield 48075
Alexander, Eugene J.......24140 Wilson, Dearborn 48128
Alexander, G. D....25799 Lathrup Blvd., Southfield 48075
Alexander, L. C..........1204 Kales Bldg., Detroit 48226
Alfonso, Manuel A..20233 Mack, Grosse Pte. Woods 48236
Alford, Elvis S...........20 Liberty St., Belleville 48111
Allaben, Robert D.............18255 W. McNichols Rd., Detroit 48219
Allen, John V.....1336 Southfield Rd., Lincoln Park 48146
Allison, Herbert C. (L)....383 Fisher Rd., Detroit 48236
Alpern, E. Bryce......2840 W. 7 Mile Rd., Detroit 48221
Alpiner, Sam......2850 E. Seven Mile Rd., Detroit 48234
Al-Sarraf, Muhyi H.......4160 John R St., Detroit 48201
Altman, Jules....14633 E. Seven Mile Rd., Detroit 48205
Altman, Raphael..17000 West 8 Mile Rd., Southfield 48075
Alvarez, Hernan, Jr......Henry Ford Hosp., Detroit 48202
Alvarez, Julian..........260 Lakeland, Grosse Pte. 48236
Alvarez, Victor M...............20211 Ann Arbor Trail, Dearborn Heights 48127
Ancog, Romulo S............1151 Taylor, Detroit 48202
Anderson, Beverly L.......977 Sexton Rd., Howell 48843
Anderson, Chas. P...Medical Director, Dept. of Social Serv., 640 Temple Ave., Detroit 48201
Anderson, Eugene C...14801 Southfield, Allen Park 48101
Anderson, Walter L...1553 Woodward Ave., Detroit 48226
Andreou, Byron....460 Eastland Ctr., Harper Woods 48237
Annessa, Domenico M. (L)............3536 Burns Ave., Detroit 48214
Ansley, Mary K. (A)....1300 Lafayette E., Detroit 48207
Anslow, Richard D............1515 Dav. Whitney Bldg., Detroit 48226
Appelman, Howard B.............1553 Woodward Ave., Detroit 48226
Arbulu, Agustin..1400 Chrysler Freeway, Detroit 48207
Arcari, Frederico A.......771 Fisher Bldg., Detroit 48202
Archambault, Henry A.............35550 Michigan Ave., Wayne 48184
Archambault, Rene F.............35550 Michigan Ave., Wayne 48184
Arciniegas, Eduardo....Henry Ford Hosp., Detroit 48202
Arehart, Burke W......340 Eastland Bldg., Detroit 48236
Arends, Norman J...302 Eastland Prof. Bldg., Detroit 48236
Arent, John G.......12600½ Gr. River Ave., Detroit 48204
Aries, C. T...4612 E. Willow Dr., B 12, Allen Park 48101
Aries, Ulve E.......Herman Kiefer Hosp., Detroit 48202
Armada, Severo R., Jr...329 Five Mile Rd., Livonia 48154
Arminski, Thos. C.......1066 Fisher Bldg., Detroit 48202
Armstrong, Mac J...441 E. Jefferson Ave., Detroit 48226

Arnstein, A. Robert. .2799 W. Grand Blvd., Detroit 48202
Arnkoff, Morris. . . . . .18241 Greenfield, Detroit 48235
Arnold, Effie E. (L). . . . . . .16520 Oakfield, Detroit 48235
Arnold, Wm. J., Jr. . . . . . .12040 Broadstreet, Detroit 48204
Arnoldi, Forrest J. . . . . .Harper Hospital, Detroit 48201
Arrington, Robyn J. . . . .7811 Oakland Ave., Detroit 48211
Ascher, Meyer S. . . . . .1508 Dav. Brodwick Twr., Detroit 48226
Ashe, Stilson R. (L) . .8031 W. Vernor Hwy., Detroit 48209
Ashley, Lowell B. (R). . . . . .5811 N. E. 21 Rd., Ft. Lauderdale, Fl. 33308
Asselin, Regis F. . . . . . .20480 Eastwood Dr., Detroit 48236
Auble, Max E. . .15901 W. Nine Mile Rd., Southfield 48075
August, Harry E. (L).26339 Woodward, Royal Oak 48072
Austin, Donald C. . . .320 Professional Bldg., Detroit 48201
Austin, Shirley. . . . . . .5224 St. Antoine St., Detroit 48202
Ausum, John D. . . . . .28661 Lathrup Blvd., Lathrup Village 48075
Avrin, Ira. . . . . . . .24777 Greenfield Rd., Southfield 48075
Axelrod, Arnold R. . . . . .15001 W. Eight Mile Rd., Detroit 48235
Axelrod, Mildred A. . . . . .3535 W. 13 Mile Rd. 305, Royal Oak 48072
Azuara, Manuel. . . . . .19150 Kelly Rd., Detroit 48236
Babcock, Lloyd K. (L). . . . . .5555 Crabtree Rd., Birmingham 48010
Babcock, Myra E. (L). . . . . .7 Poplar Park, Pleasant Ridge 48069
Babcock, Paul W. . . . .29584 Five Mile Rd., Livonia 48154
Babcock, Warren W. (R). . . . . .2661 Northeast Ninth, Pompano Beach, Fl. 33062
Bach, Walter F. (L). . . . . .23369 Longview, Dearborn Hghts. 48127
Bacher, Burton J. . . . . .1015 Kales Bldg., Detroit 48226
Bachman, Morris E. . .10326 W. 7 Mile Rd., Detroit 48221
Bacon, Vinton A. (L). . . . .18400 Livernois, Detroit 48221
Bader, Benj. H. . . . . . .2654 W. Grand Blvd., Detroit 48208
Bady, Arthur J. (M). . . . . . .832 T.A.C. Hosp., Box H147, Cannon A.F.B., Clovis, N.M. 88101
Baer, Marga. . . . . .16321 Mack Ave., Detroit 48224
Baer, Walter. . . . . .16321 Mack Avenue, Detroit 48224
Bagley, Harry E. (A). . . . . .7541 Oakman Blvd., Dearborn 48126
Bahra, Robt. J. . . . . .20905 Greenfield, Southfield 48075
Bailey, Louis J. . . . . .20905 Greenfield, Southfield 48075
Baima, Margaret A. . . . . .1212 Dav. Whitney Bldg., Detroit 48226
Baker, Clarence (L). . . . . .J 16 Palmetto Trl. Pk., Palmetto, Fl. 33561
Bakst, Joseph A. (L). . . . . .10 W. Warren, Detroit 48201
Balaga, Frank T. . . . . .1840 Holbrook, Detroit 48212
Balberor, Harry. . . . . .275 W. Grand Blvd., Detroit 48216
Balcerski, Matthew A. . . . .855 Fisher Bldg., Detroit 48202
Ballard, Donald R. . . . . . . .20520 Audette, Dearborn 48124
Balog, Janos. . . . . .2300 Oak St., Wyandotte 48192
Balow, Ross M. . . . . .18700 Meyers Rd., Detroit 48235
Balser, Chas. W. (L). . . . . . .13931 Gratiot, Detroit 48205
Baltz, Donald L. 23422 Ford Rd., Dearborn Heights 48127
Baniriah, Nana N. . . . . .302 Eastland Med. Bldg., 17800 E. Eight Mile, Detroit 48236
Banish, Gerald. . . . . . . .23100 Cherry Hill, Dearborn 48124
Banks, Thomas L. . .18597 W. 10 Mile Rd., Southfield 48075
Barak, Lewis R. . .7448 W. Seven Mile Rd., Detroit 48221
Barak, Stuart. . . . . .18241 Greenfield, Detroit 48235
Baran, Alphonse W. . .15841 W. Warren St., Detroit 48228
Barbaglia, Louis C. . . . . .16378 Harper, Detroit 48224
Barber, Radivoj R. . . . . . .864 S. Main St., Plymouth 48170
Bardenstein, M. B. . .17000 W. 8 Mile Rd., Southfield 48075
Barefield, Alwin S. . . . .10244 W. 7 Mile Rd., Detroit 48221
Barenholtz, Benj. . . . . . .20905 Greenfield, Southfield 48075
Barillas, Oscar G. . .23935 W. Outer Dr., Melvindale 48127
Barker, David H. . . . . .7220 Gratiot Ave., Detroit 48213
Barland, Oscar (A) . .8401 Woodward Ave., Detroit 48202
Bar Levav, Reuven. . . . . .865 Fisher Bldg., Detroit 48202
Barlow, Myron. . . . . .18050 Mack, Grosse Pte. 48236
Barnett, Louis L. (L). . . . . . . .640 Temple, Detroit 48201
Barnett, Morton. . . . .735 Ardmoor Rd., Birmingham 48010
Barone, C. Gerald. . . .751 Chestnut St., Birmingham 48008
Barrett, Raymond J. . . . . .18280 Fairfield, Detroit 48221
Barrett, Wyman D. (L). . . . . .362 McKinley, Grosse Pte. Farms 48236
Barron, James. . . . . . . .Henry Ford Hosp., Detroit 48202
Barron, Wm. H. . . . . . . .14938 Livernois St., Detroit 48238
Barsky, David. . . . . .100 Oak St., Wyandotte 48192
Barton, Jos. R. (L). . . . . .19619 W. Warren, Detroit 48228
Baruch, Robert J. . . . . . .18737 Hilton Rd., Southfield 48075
Baskin, Sidney. . . . . . .19630 W. McNichols, Detroit 48219
Bassett, Joseph S. . . . . . .1300 E. Lafayette, Detroit 48207
Batchelor, Thomas M. . . . . .3790 Woodward Ave., Detroit 48201
Bates, Gaylord S. . . . . . .861 Monroe Blvd., Dearborn 48124
Battle, John M. . . . . . .6904 Charlesworth, Dearborn 48127
Bauer, A. Robt. (L). . . . . .19268 Grand River Ave., Detroit 48223
Bauer, Benedict J. . . . . . . .16451 Schoolcraft, Detroit 48227
Bauer, Lester E. (A). . . . . .4 Woodside Pk., Pleasant Ridge 48069
Bauer, Ralph E. . . . . . .Henry Ford Hospital, Detroit 48202
Bauer, Raymond B. . . . . . . .Harper Hospital, Detroit 48201
Baugh, Evelyn F. . . . . .9191 Whittier, Detroit 48224
Baugh, Richard H. . .24216 Michigan Ave., Dearborn 48124
Baugh, Robert F. . . . . .9191 Whittier, Detroit 48224
Baumer, Moe. . . . . .10 Peterboro, Detroit 48201
Baumgarten, Elden C. (L). . . . . . . .1062 Lochmoor Blvd., Grosse Pte. Woods 48236
Baumgarten, Thos. W. . . . . .20867 Mack Ave., Grosse Pte. 48236
Bautista, Joaquin P. . . . . .20503 Dequinder, Detroit 48234
Baxter, Seymour. . . . . .19925 Livernois, Detroit 48221
Bazil, Gilbert M. . . . . .14200 Puritan, Detroit 48227
Beach, Watson (L). . . . . . . .220 E. Butler, Bad Axe 48413
Beam, A. Duane. . . . . .20160 Mack Ave., Grosse Pte. Woods 48236
Beamer, Geo. D. . . .14853 Michigan Ave., Dearborn 48126
Beard, James E. . . . . .23801 Fordson, Dearborn 48127
Beaudoin, Jacques. . . . .17770 Mack, Grosse Pointe 48224
Beck, Stanley M., Jr. . . .13118 Fort St., Wyandotte 48192
Becker, Abraham. . . .3790 Woodward Ave., Detroit 48201
Beckett, Peter G. S. . . .951 E. Lafayette St., Detroit 48207
Beckett, Victoria L. (A). . . . . .1420 Anita, Grosse Pte. Woods 48236
Becklein, Clarence L. . . . . .14351 E. Warren Ave., Detroit 48215
Beckman, Hugh. . . . . .20001 Greenfield, Detroit 48235
Beckwith, Carl C. . . . . .15865 Wyoming, Detroit 48238
Bedell, Archie A. . . . . .15545 Mack Ave., Detroit 48224
Bedwell, Wm. L. . . . . .1211 Kales Bldg., Detroit 48226
Beebe, Willard E. . . . . . .7636 Allen Rd., Allen Park 48101
Beekhuis, G. Jan. . . . . .1326 St. Antoine St., Detroit 48226
Beeks, Billy. . . . . .8824 Puritan, Detroit 48238
Beeuwkes, L. E. . . . .13014 Mackenzie Ave., Detroit 48228
Behan, Robt. C. . . . . . . .1 Woodward Ave., Detroit 48226
Beitman, Max R. . . . . .510 Kales Bldg., Detroit 48226
Beizai, Khosrow. . . . . . . .22101 Moross Rd., Detroit 48236
Belamaric, Juan. . . .1400 Chrysler Expwy., Detroit 48207
Belanger, W. Geo. . . . . .1041 Harvard, Detroit 48230
Belden, Darwin F. . . . . .2424 Puritan, Detroit 48238
Bell, J. Kenner (L) . . .660 Woodward Ave., Detroit 48226
Benavides, Claude. . . . . .25750 W. Outer Dr., Lincoln Park 48146
Bende, Sandor F. . . . . . . .15863 Garfield, Allen Park 48101
Beninson, Joseph. . . . . . . .Henry Ford Hosp., Detroit 48202
Bennett, Germany E. . . . . . .1446 E. Forest, Detroit 48207
Bennett, Harry B. . . . . .7015 Intervale, Detroit 48238
Bennett, H. Stanley. . . .15101 Southfield, Allen Park 48101
Bennett, James A. . . . . . . .6375 Pelham, Allen Park 48101
Bennett, Sanford A. . . . . .15301 W. Nine Mile Rd., Oak Park 48237
Bennish, Arvin. . . . . .17411 Greenfield, Detroit 48235
Bennish, E. Leo. . . .14438 W. Six Mile Rd., Detroit 48240
Benson, Clifford D. . .1553 Woodward Ave., Detroit 48226
Benson, Davis A. . . . . .17563 Greenfield, Detroit 48235
Benson, Paul J. . . . . .227 N. Sheldon Rd., Plymouth 48170
Benson, Virginia M. (L). . . .34636 Grove, Livonia 48154
Bentley, Robert H. . . . . . .7220 Gratiot Ave., Detroit 48213
Bentley, Wm. G. . . . . .50 Westminster, Detroit 48202
Berdayes, Pedro P. . . . . .15345 Windmill Pte. Dr., Grosse Pte. 48236
Berger, Edwin L. . . . .7301 Schaefer Rd., Dearborn 48126
Bergman, Gary D. . . . . .7310 W. 7 Mile Rd., Detroit 48221
Bergman, Murray S. . . .4400 Livernois Ave., Detroit 48210
Bergo, Howard L. . . . .901 W. Grand Blvd., Detroit 48208

Berkas, Ernest M.........V.A. Hospital, Dearborn 48121
Berke, Joseph J..........3333 E. Jefferson, Detroit 48207
Berke, Sydney S.........3333 E. Jefferson, Detroit 48207
Berlin, Allen B.....17000 W. 8 Mile Rd., Southfield 48075
Berman, Martin B.......7411 Third Ave., Detroit 48202
Berman, Robt. H. (L)....2111 Woodward, Detroit 48201
Berman, Sidney L.........60 W. Hancock, Detroit 48201
Bernard, Henri....414 Dav. Whitney Bldg., Detroit 48226
Bernard, Walter G. (L)......910 Chalmer, Detroit 48215
Bernbaum, Bernard (L).........13345 W. Six Mile Rd., Detroit 48235
Bernstein, Saml. S...15901 W. 9 Mile Rd., Southfield 48075
Bernys, Conrad F.........3815 Pelham, Dearborn 48124
Berridge, William L...Chevrolet Motor Co., Livonia 48151
Berry, Jos. E.........19242 W. 7 Mile Rd., Detroit 48219
Bertram, Karl R.........461 Fisher Bldg., Detroit 48202
Besancon, John H........345 Lodge Drive, Detroit 48214
Best, Thos. H. E. (L)...........9221 E. Jefferson Ave., Detroit 48214
Betanzos, G...............22770 Kelly, E. Detroit 48021
Bethea, John H...............49000 W. Seven Mile Rd., Northville 48167
Bialik, Michael H...14853 Michigan Ave., Dearborn 48126
Bicknell, Frank B...938 Dav. Whitney Bldg., Detroit 48226
Bielawski, John G.............825 David Whitney Bldg., Detroit 48226
Bihl, John H.......10531 Farmington Rd., Livonia 48150
Billingslea, Thos. H.......3790 Woodward, Detroit 48202
Bing, Richard J.....1400 Chrysler Expwy., Detroit 48207
Binns, Philip M..........573 Fisher Bldg., Detroit 48202
Birch, John R.....633 Dav. Whitney Bldg., Detroit 48226
Birk, Robert E...19787 Mack, Grosse Pointe Woods 48236
Birkam, Fred F.......7301 Schaefer Rd., Dearborn 48126
Birkhill, F. Ross...31 Shady Hollow Dr., Dearborn 48124
Birmingham, D. J......Wayne State Univ., Detroit 48207
Birmingham, John R...........14215 W. McNichols Rd. Detroit 48235
Birndorf, Leonard.......18317 John R St., Detroit 48203
Bissell, G. W............V.A. Hospital, Allen Park 48101
Bittker, Isadore I. (L).............3321 Rochester Rd., Royal Oak 48073
Bittrich, Norbert M...16001 9 Mile Rd., Southfield 48075
Black, Earl D.......20340 Harper, Harper Woods 48236
Black, Robert W...817 Dav. Whitney Bldg., Detroit 48226
Blain, Alexander, III....2201 E. Jefferson, Detroit 48207
Blain, James H., Jr.......935 Grand Marais, Detroit 48230
Blaine, Max.............13700 Woodward, Detroit 48203
Blair, Wm. F.............81 E. Kirby St., Detroit 48202
Blanchard, Russell S.............12858 Woodward Ave., Detroit 48203
Blanks, Douglas H......12811 Northline, Southgate 48192
Blatt, Ronald W..................32226 Tall Timber Dr., Farmington 48024
Bleier, Alfred (A)..8801 Kingswood, #205, Detroit 48221
Blinkhorn, David H........25709 Salem, Roseville 48066
Block, Duane L..........3001 Miller Rd., Dearborn 48126
Block, Melvin A.....2799 W. Grand Blvd., Detroit 48202
Blodgett, James B.......76 W. Adams St., Detroit 48226
Blodgett, Wm. H.......74 W. Adams Ave., Detroit 48226
Blondy, Marshall J...19009 W. 7 Mile Rd., Detroit 48219
Bloom, Albert............6484 Chene St., Detroit 48211
Bloom, Arthur R. (L)........16500 N. Park Dr., #1406, Southfield 48075
Bloom, Victor...........951 E. Lafayette, Detroit 48207
Blosen, Rosemarie........2160 Gorno Ct., Trenton 48183
Bluhm, Gilbert B.......Henry Ford Hosp., Detroit 48202
Blum, George L....15901 W. 9 Mile Rd., Southfield 48075
Blumenthal, Frank S...........261 Brady, Detroit 48201
Blumenthal, Franz L. (L)............2686 Heatherway, Ann Arbor 48104
Blumer, Abraham.22341 W. Eight Mile Rd., Detroit 48219
Boccaccio, John L..........11532 Morang, Detroit 48224
Boccia, James J.........15761 E. Warren, Detroit 48224
Boddie, Arthur W.........2737 Chene St., Detroit 48207
Bogucki, Chester J...............18620 Walmer Lane, Birmingham 48009
Bogue, Robt. E.............15901 W. 9 Mile Rd., #604, Southfield 48075
Bogusz, Ladislaus (R)..............29215 Maranya Rd., Homestead, Fl. 33030
Bohn, Z. Stephen...327 Professional Bldg., Detroit 48201
Bohne, A. Waite........Henry Ford Hosp., Detroit 48202
Boland, John R. (R)........Box 50, Grand Marais 49839
Boles, Murray...26381 Dundalk Lane, Farmington 48024
Bolstad, Donald S.......Henry Ford Hosp., Detroit 48202
Bolter, Sidney........18946 W. McNichols, Detroit 48219
Bolton, Norman.........19321 Greenfield, Detroit 48235
Bolton, Russell P., Jr....18530 Grand River, Detroit 48223
Boman, Robert H..............246 Eastland Prof. Bldg., Harper Woods 48236
Boneta, Otto F. W. (A)..................1151 Taylor, Herman Kiefer Hospital, Detroit 48202
Bonilla, Jaime........25447 Plymouth Rd., Detroit 48239
Bookstein, Abraham M...............1725 Pinecrest Dr., Ferndale 48220
Boone, Geo. F....................81 Woodland Shores, Grosse Pte. Shores 48236
Booth, Earnest.........Womans Hospital, Detroit 48201
Borchak, Robert G....17800 E. Eight Mile, Detroit 48236
Borden, Igor I........15361 Plymouth Rd., Detroit 48227
Borin, Maurice C.......18115 Fairfield St., Detroit 48221
Bornstein, Melvin.............17600 Northland Pk. Ct., Southfield 48075
Bornstein, Sidney.........16965 Hamilton, Detroit 48203
Borrego, Jose M.........1342 Whittier, Grosse Pte. 48236
Bott, Edmund T............1629 Ford, Wyandotte 48192
Botvinick, Isadore....13701 W. 7 Mile Rd., Detroit 48235
Boutrous, Thos. A.....15801 W. McNichols, Detroit 48235
Bower, Donald W......8863 Woodside, Grosse Ile 48138
Bowers, Leo J....11200 E. McNichols Rd., Detroit 48234
Bowersox, LeRoy W.................368 Franklin Ave., Redlands, Calif. 92373
Bowlby, James R...15420 Farmington Rd., Livonia 48154
Boyajian, Albert.......10963 Farmington, Livonia 48150
Boyce, Charles R.....3790 Woodward Ave., Detroit 48201
Boyd, Albert L............9845 Reeck, Allen Park 48101
Boyd, John H. (L).....2615 W. Jefferson, Trenton 48183
Boyle, Eugene H..................572 Thorn Tree Rd., Grosse Pte. Woods 48236
Bracken, Andrew H. (L)..5460 Schaeffer, Dearborn 48126
Braden, Robt. G..........2300 Oak St., Wyandotte 48192
Bradfield, Horace F...3008 E. Grand Blvd., Detroit 48202
Bradfield, R. John........955 Fisher Bldg., Detroit 48202
Braley, Wm. N. (L)....12897 Woodward, Detroit 48203
Bramigk, Fritz W. (L).....178 Lakewood, Detroit 48215
Brand, Benj.....1201 David Whitney Bldg., Detroit 48226
Brane, Adolfo J..........Lafayette Clinic, Detroit 48207
Braun, Lionel............18644 Muirland, Detroit 48221
Braun, Robert A.....18610 Hartwell Ave., Detroit 48235
Braverman, Morris M...........1860 St. John Rd., 32-P, Seal Beach, Calif. 90740
Bredau, Frank N., Jr...24781 Five Mile Rd., Detroit 48239
Breiner, Sander J...7410 Franklin Rd., Birmingham 48010
Brekke, Viola G...369 Glendale St., Highland Park 48203
Bremer, John P..............17700 Mack, Detroit 48224
Bremer, Wm. M.........15641 E. Warren, Detroit 48224
Breneman, Gerald M............28300 Forest Brook Dr., Farmington 48024
Brennan, Michael J................1168 Three Mile Dr., Grosse Pte. 48236
Brent, Morris S.......1330 Strathcona Dr., Detroit 48203
Brent, Robert L...1355 David Whitney Blg., Detroit 48226
Bresnahan, Boyd K................17600 W. 8 Mile Rd., Southfield 48075
Brey, Norman W.............1900 Dav. Broderick Twr., Detroit 48226
Brickman, Murray.....24777 Greenfield, Southfield 48075
Briegel, Walter A. (R).............3233 N. E. 34th St., Ft. Lauderdale, Fl. 33308
Briggs, Wm. J...1900 Dav. Broderick Twr., Detroit 48226
Bringard, Elmer L.........18110 Fairfield, Detroit 48227
Brinkman, G. L............Harper Hosp., Detroit 48201
Briski, Jacob E...1058 Blairmoor, Grosse Pte. Woods 48236
Brisson, John E..........17032 Fort St., Riverview 48192
Brisson, Jos. C. (R)..................23112 Westbury, St. Clair Shores 48080
Bristol, Wm. R.............189 Claverly, Detroit 48236
Broadman, Sylvan A...25705 Middlebelt, Farmington 48024
Brock, Donald R.....36475 Five Mile Rd., Livonia 48154
Broderson, Harvey S. (R)..........10720 W. Jefferson, River Rouge 48218
Bromme, Wm. (L).......10 Peterboro St., Detroit 48201

Brooks, Eugene M............609 Northland Med. Bldg., Southfield 48075
Brooks, Nathan..............7401 3rd St., Detroit 48202
Brosius, Chas. O....16981 Farmington Rd., Livonia 48154
Brosius, Wm. L. (L).............1823 Fair Oak Court, Rochester 48063
Brown, Andrew G.....20905 Greenfield, Southfield 48075
Brown, Audrey O. (L)............1795 Cedar Hill Dr., Birmingham 48010
Brown, Carlton F.....22335 Lagaronne, Southfield 48075
Brown, Chas. H..........2387 Fort St., Wyandotte 48192
Brown, Donald........Henry Ford Hosp., Detroit 48202
Brown, Eli M...13123 La Salle, Huntington Woods 48070
Brown, Frances (L)
Brown, Gordon T.......13000 Hayes Ave., Detroit 48205
Brown, James C...........5050 Joy Road, Detroit 48204
Brown, John R...1145 Dav. Whitney Bldg., Detroit 48226
Brown, Kenneth A.........17316 Livernois, Detroit 48221
Brown, Oscar A...1633 Dav. Whitney Bldg., Detroit 48226
Brown, Richard O...........1800 Tuxedo, Detroit 48206
Brown, Robt. A. (A)........1524 Vernon, Trenton 48183
Brown, Saml. M..........21821 Harding, Oak Park 48237
Brown, Saul....6890 White Pine Dr., Birmingham 48010
Brown, Stanley H. (L).........8544 W. McNichols Rd., Detroit 48221
Brown, Thos. A.....5430 W. Warren Ave., Detroit 48210
Brownell, H. H.....8222 Woodcrest Dr., Grosse Ile 48138
Brownell, Paul G...18916 Woodward Ave., Detroit 48203
Bruce,Thomas A...................2501 Wilshire Blvd., Oklahoma City, Ok. 73120
Bruder, Robt. C.....4520 Firestone Ave., Dearborn 48126
Bruer, Edgar S..........12170 Fort St., Wyandotte 48192
Bruer, Edwin L.........12170 Fort St., Wyandotte 48192
Brush, Brock E......2799 W. Grand Blvd., Detroit 48202
Bruton, Martin F........341 Massachusetts, Detroit 48203
Bryan, Donald I....15901 W. 9 Mile Rd., Southfield 48075
Buck, Raymond E.......1575 E. Lafayette, Detroit 48207
Buerki, Robin C.........Henry Ford Hosp., Detroit 48202
Buller, Harry L. (L)................167 E. Center St., Manchester, Ct. 06040
Burge, Robert H.........23843 Joy Rd., Dearborn 48127
Burke, Ralph M.....580 University Pl., Grosse Pte. 48236
Burnham, Thomas K.....Henry Ford Hosp., Detroit 48202
Burns, Robert E........Henry Ford Hosp., Detroit 48202
Burns, Robt. T.........11110 Morang Rd., Detroit 48224
Burnside, Howard B...................33 Oakland Park, Pleasant Ridge 48069
Burnstine, David.........18400 Schaefer, Detroit 48235
Burnstine, Julius Y. (L).....45 Owen Ave., Detroit 48202
Burnstine, Perry P.....2329 W. Grand Blvd., Detroit 48208
Burr, Geo. C. (L)....1177 Devonshire, Grosse Pte. 48236
Burroughs, Roswell G.......1309 David Whitney Bldg., Detroit 48226
Burrows, Howard A. (L)........10423 W. Warren Ave., Dearborn 48126
Burrows, John H.......22101 Moross Rd., Detroit 48236
Burstein, Harry S....2950 W. Grand Blvd., Detroit 48202
Burstein, I. Marvin...2950 W. Grand Blvd., Detroit 48202
Burton, De Witt T. (L)....54 Arden Park, Detroit 48202
Burton, Irving F......................26912 York Rd., Huntington Woods 48070
Bush, Glendon J......18901 W. McNichols, Detroit 48219
Butler, James E......2177 W. Grand Blvd., Detroit 48208
Butler, John D.......2173 W. Grand Blvd., Detroit 48208
Butler, Lawrence H...14521 East 7 Mile Rd., Detroit 48205
Butler, Richard G.........1922 Monroe, Dearborn 48124
Butler, Volney N. (L)..28 W. Adams Ave., Detroit 48226
Buttrum, Edward J......14755 Fenkell St., Detroit 48227
Byers, Glen L. (A)..Detroit General Hosp., Detroit 48226
Cabral, Hector H...24860 River Heights, Southfield 48075
Cabrera, Enrique.....35337 W. Warren, Westland 48184
Cadger, Ralph E. (M)...........719 New Center Bldg., Detroit 48202
Cahalan, Jos. L..........15830 Fort St., Southgate 48192
Cahn, Bernard J. (A)..Detroit Gen. Hosp., Detroit 48226
Cain, Waldo L......8401 Woodward Ave., Detroit 48202
Caldwell, Geo. L. (L)............12017 Joseph Campau, Detroit 48212
Caldwell, John R.....2799 W. Grand Blvd., Detroit 48202
Callaghan, Regis L......22146 Ford Rd., Dearborn 48128
Calmidis, Yani V........24800 Cromwell, Franklin 48025
Calwell, John G.....714 New Center Bldg., Detroit 48202
Cameron, Arthur H. (L).............2853 Biddle Ave., Wyandotte 48192
Cameron, Duncan A.......2021 Monroe, Dearborn 48124
Campbell, Fredk. W., Jr.........648 N. Woodward Ave., Birmingham 48011
Campbell, Harvey E.....3 Robindale Ct., Dearborn 48124
Campbell, L. F...18101 Oakwood Blvd., Dearborn 48124
Campbell, Malcolm D. (L).........1520 N. Gulley Rd., Dearborn 48128
Campbell, Mary B. (L)................10454 Kingston, Huntington Woods 48070
Campbell, Robt. E......20901 Moross Rd., Detroit 48236
Campbell, Ruth B...........1536 David Whitney Bldg., Detroit, 48226
Campbell, Thelma M. 2355 Monroe Blvd., Dearborn 48124
Camps, Enrique........1966 Fairway, Birmingham 48009
Cancino-Samson, E. B...18700 Meyers Rd., Detroit 48235
Cantor, Herbert C................26831 N. Woodward, Huntington Woods 48070
Cantor, Meyer O...................4850 Charing Cross, Bloomfield Hills 48013
Cantow, Lawrence A.............19291 Warrington Dr., Detroit 48221
Cantrell, Mary E........Henry Ford Hosp., Detroit 48202
Capellari, Elmer E.......901 Mutual Bldg., Detroit 48226
Capetamakis, D. C.....27127 Southerland, Warren 48093
Capobres, David B.....3001 E. 7 Mile Rd., Detroit 48234
Caputo, Jos. M......2021 Monroe Blvd., Dearborn 48124
Caputo, Nancy T.....17712 Mack Ave., Grosse Pte. 48236
Capuzzi, Eugene T...................19061 La Crosse, Lathrup Village 48075
Caraway, James E. (R)..................R. 1, Box 503, Franklin, N.C. 28734
Carbone, Louis........14711 Gratiot Ave., Detroit 48205
Carbonell, Tomas.......353 Devonshire, Dearborn 48124
Carlisle, John C.......15101 Southfield, Allen Park 48101
Carlson, Harold W...18070 Wildemere Ave., Detroit 48221
Carman, Kenneth W...30928 Ford Rd., Garden City 48135
Carp, Jos.................8717 Van Dyke, Detroit 48213
Carpenter, C. J. (L)........P. O. Box 390, Wayne 48184
Carpenter, Wm. S.............18255 W. McNichols Rd., Detroit 48219
Carreon, Francisco P......6382 Trumbull, Detroit 48201
Carrick, Lee........18050 Mack Ave., Grosse Pte. 48236
Carroll, Elmer H. (L)...9920 Stoepel Ave., Detroit 48204
Carroll, Jerome G.....29588 Five Mile Rd., Livonia 48154
Carroll, Lona B. (L)..........938 David Whitney Bldg., Detroit 48226
Carson, Herman J........19149 7 Mile Rd., Detroit 48219
Carstens, Henry R. (L)..........6896 N. Clunbury Rd., Birmingham 48010
Carter, James A. U...19271 Strathcona Dr., Detroit 48203
Carter, John M. (L)............2860 N. E. 55th Court, Ft. Lauderdale, Fl. 33308
Carter, Leland F...........750 Middlesex, Detroit 48230
Casas, Miguel A.......9613 E. Outer Dr., Detroit 48213
Case, Hilda B............261 Mack Blvd., Detroit 48201
Cash, Morton B........St. Mary's Hospital, Livonia 48151
Cash, Ralph....15705 W. Ten Mile Rd., Southfield 48075
Cassel, Harry E........6742 Park Ave., Allen Park 48101
Castle, Maurice E.......20211 Greenfield, Detroit 48235
Catalano, Joseph V.....20905 Greenfield, Southfield 48075
Caughey, Andrew F., Jr...15256 Levan Rd., Livonia 48154
Caughey, Edgar H......11301 Whittier St., Detroit 48224
Caumartin, Fred E.......17184 Wildemere, Detroit 48221
Cellar, Frank A., Jr..............26789 Woodward Ave., Royal Oak 48072
Ceravolo, Albert J........468 Cadieux Rd., Detroit 48230
Ceresko, Anthony R.....9187 Mason Place, Detroit 48209
Cetnar, Eugene J.............4322 Bishop, Detroit 48224
Chalat, Ned I.......1553 Woodward Ave., Detroit 48226
Chall, Henry G. (L)...........2941 W. McNichols Rd., Detroit 48221
Chapin, Sidney E.......125 N. Military, Dearborn 48124
Chapman, Aaron L. (L)............406 W. Frisco Rd., Pensacola, Fl. 32507
Chapman, E. Forrest......36825 Bibbins, Romulus 48174
Chapman, Paul T........1151 Taylor Ave., Detroit 48202
Chapman, Roland H...3790 Woodward Ave., Detroit 48201
Chapnick, Henry A..........19335 Prairie, Detroit 48221

Chapper, Barbara M........861 Monroe, Dearborn 48124
Charnas, Sidney...............15901 W. Nine Mile Rd., Southfield 48075
Charnley, Arnold D.....1678 Merriman Rd., Wayne 48184
Chase, Clyde H. (R).............2922 Dawes St. S.E., Grand Rapids 49508
Chason, Jacob L...........1401 Rivard St., Detroit 48207
Chavis, William M........13800 Livernois, Detroit 48238
Check, Frank E........76 W. Adams Ave., Detroit 48226
Chehab, Henri E....314 Lafayette Towers, Detroit 48207
Chen, Allen S. Y....11933 Belleville Rd., Belleville 48111
Chen, Calvin H............State Hosp., Northville 48167
Chen, Shek C...........1326 St. Antoine, Detroit 48226
Chen, You Chen.......Childrens Hospital, Detroit 48202
Chen, Vincent V...........1800 Tuxedo, Detroit 48206
Cherenzia, B. J...7437 Wellbourne Ct., Birmingham 48010
Chester, Alice....25085 Coolidge Hwy., Oak Park 48237
Chester, Wm. P...3800 Woodward, Rm. 802, Detroit 48201
Childs, George M.......1059 Fisher Bldg., Detroit 48202
Chipman, Willard A. (L)............14613 Rutland Rd., Detroit 48227
Chipoco, Adolfo M.....25210 Grand River, Detroit 48240
Chodorkoff, Bernard....19435 Shrewsbury, Detroit 48221
Chown, Marion C..........2025 Ford, Wyandotte 48192
Christensen, R. C...................20861 Mack Ave., Grosse Pte. Woods 48236
Christopher, James G................20295 Douglas Ct., Birmingham 48010
Chrouch, Laurence A. (L)......Pleasant Hill, Tn. 38578
Church, Aloysius........19570 Bretton Dr., Detroit 48223
Cioffari, Mario S.............15924 W. Seven Mile Rd., Detroit 48235
Clapper, Muir...........1401 Rivard St., Detroit 48207
Clark, Arthur M.........401 River Lane, Dearborn 48124
Clark, Clarence M. (L)............2605 Holbrook Ave., Detroit 48212
Clark, Max D.....Wm. Beaumont Hosp., Royal Oak 48067
Clark, Wm. P...........1808 Baldwin, Ann Arbor 48104
Clarke, Chas. N..........21950 Greenfield, Detroit 48237
Clarke, Norman E. (L)...21950 Greenfield, Detroit 48237
Clarke, Norman E., Jr.....21950 Greenfield, Detroit 48237
Clarke, Robt. B........76 W. Adams Ave., Detroit 48226
Clemens, Raymond R.........23843 Joy, Dearborn 48127
Clermont, Volna............5050 Joy Rd., Detroit 48204
Clifford, John E..............18348 Mack, Detroit 48236
Climie, Andrew R. W.....Harper Hospital, Detroit 48201
Cline, Richard S...401 N. Oneida St., Appleton, Wis 54911
Clune, John P. (M)...........226 Eastland Prof. Bldg., Harper Woods 48236
Coates, E. Osborne, Jr...Henry Ford Hosp., Detroit 48202
Cobane, John H. (L)...10 Peterboro Ave., Detroit 48201
Cochrane, Edgar G...503 Med. Arts Bldg., Detroit 48203
Cocorelis, S. G. (A)..Jack Garris, Municipal Court Bldg., Ann Arbor 48104
Cohen, David M. (A).............Wayne State Univ., 1400 Chrysler Expwy., Detroit 48207
Cohen, Herbert H....12700 W. 7 Mile Rd., Detroit 48235
Cohn, Danl. E.............409 Fox Bldg., Detroit 48201
Cohn, S. Leonard................28505 Southfield Rd., Lathrup Village 48075
Cohoe, Don A. (L)..18916 Woodward Ave., Detroit 48203
Cole, James E. (L).....344 Glendale Ave., Detroit 48203
Cole, Wyman C. C. (L)..........1116 Leisure Lane, #3, Walnut Creek, Ca. 94529
Cole, Wyman C. C., Jr.................23843 Joy Road, Dearborn Hgts. 48127
Coleman, Margarete W. (L).........4214 N. Woodward, Royal Oak 48072
Coleman, Wm. G...20526 Grand River Ave., Detroit 48219
Coles, Thomas B., Jr.......Grace Hospital, Detroit 48201
Collings, M. Raymond (A)........9201 W. Outer Drive, Detroit 48219
Collins, James E...13103 W. Chicago Blvd., Detroit 48228
Collins, James W.........13800 Livernois, Detroit 48238
Colvin, Leslie T. (R)............15015 Glastonbury Rd., Detroit 48223
Colyer, Raymond G. (R)..284 Pilgrim, Birmingham 48009
Combs, Julius V.............2424 Puritan, Detroit 48238
Comstock, Lawrence A.....3700 West Rd., Trenton 48183
Conklin, Emma J....Wayne Co. Gen. Hosp., Eloise 48132
Conley, Lowry C. M. (L)..99 Tuxedo Ave., Detroit 48203
Connelly, Richard C...............1360 Three Mile Dr., Grosse Pte. 48236
Connolly, Paul J......3800 Woodward Ave., Detroit 48201
Connor, Phyllis M.....Henry Ford Hosp., Detroit 48202
Connors, John J....25657 Southfield Rd., Southfield 48075
Conway, Gerald F............938 David Whitney Bldg., Detroit 48226
Cook, Carla A..........Henry Ford Hosp., Detroit 48202
Cook, James A........2246 20th Street, Wyandotte 48192
Cook, James C............3825 Brush St., Detroit 48201
Cookinham, Frank......999 S. Highland, Dearborn 48124
Cooksey, Warren B. (L)..........3535 W. 13 Mile Rd., Royal Oak 48072
Cooper, James B.....18150 Mack Ave., Grosse Pte. 48236
Cooper, Ralph R...1515 Dav. Whitney Bldg., Detroit 48226
Cooper, Richard F...............18100 Shadbrook Dr., Northville 48167
Cooper, Thomas M...8445 E. Jefferson Ave., Detroit 48214
Corbeille, Catherine (L)..........3011 W. Grand Blvd., Detroit 48202
Corbett, David P.........Harper Hospital, Detroit 48201
Cortez, Joseph A.....19350 W. McNichols, Detroit 48219
Costello, Russell T...3001 W. Grand Blvd., Detroit 48202
Costello, Stephen D.....9435 Island Dr., Grosse Ile 48138
Cotant, John F.............15901 W. 9 Mile Rd., #420, Southfield 48075
Coto, Moises G.............VA Hosp., Allen Park 48101
Cotton, Schuyler O. (R)......2332 Carson, Detroit 48209
Courville, Chas. J.............703 Northland Med. Bld., Southfield 48075
Cowan, Wilfrid (L)..............416 North Shore Dr., St. Clair Shores 48080
Cowen, Leon B. (L)..............10225 N. Balboa Dr., Sun City, Az. 85351
Cowen, Robt. L. (L)........91 E. Kirby, Detroit 48202
Cox, Frank, Jr..........Henry Ford Hosp., Detroit 48202
Coyle, James E......17770 Mack Ave., Grosse Pte. 48224
Craig, Roy D..........3790 Woodward Ave., Detroit 48201
Craig, Roy E...74 Fontana Lane, Grosse Pte. Shores 48236
Crawley, Eugene H...................885 Bloomcrest, Bloomfield Hills 48013
Crews, Thos. H. (L)..3011 W. Grand Blvd., Detroit 48202
Crippen, Edward F.............316 City County Bldg., Detroit 48226
Crockett, E. E. J............1327 Nicolet, Detroit 48207
Croll, Leo J..........12703 W. 7 Mile Rd., Detroit 48235
Croll, Maurice...12703 W. Seven Mile Rd., Detroit 48235
Crook, Chas. L.....60 Colorado St., Highland Park 48203
Cross, Harold E...68 N. Deepland Rd., Grosse Pte. 48236
Crossen, Robert J.....933 David Wh. Bldg., Detroit 48226
Croushore, James E. (L)......561 N.E. Golden Harbour, Boca Raton, Fl. 33432
Cruz, Victor M.............15901 W. 9 Mile Rd., #303, Southfield 48075
Cserhalmi, Maria V......1302 Beaconsfield, Detroit 48230
Cubberley, Robt. B.......1800 Tuxedo St., Detroit 48206
Cullis, Frank............261 Mack Blvd., Detroit 48201
Curhan, Robert P.......18709 Meyers Rd., Detroit 48235
Curtis, Frank E. (L)....273 Kenwood Ct., Detroit 48236
Curtiss, Wm. P...22631 Mack Ave., St. Clair Shores 48080
Cusick, Paul L.....15901 W. 9 Mile Rd., Southfield 48075
Cyrowski, Gerald A...........15901 W. Nine Mile Rd., Southfield 48075
Daignault, F. M.......20905 Greenfield, Southfield 48075
Daitch, Harold J...22341 W. Eight Mile Rd., Detroit 48219
Daitch, Martin H....15244 Middlebelt Rd., Livonia 48154
Dale, Esther H. (L)......1401 Rivard St., Detroit 48207
Dale, Mark............3702 E. 8 Mile Rd., Detroit 48234
Dal Santo, G.............1401 Rivard St., Detroit 48207
Daly, Eugene T............24781 Fenkell, Detroit 48223
Danforth, James C., Jr...............20175 Mack Ave., Grosse Pte. Woods 48236
Danforth, Robt. D...................20175 Mack Ave., Grosse Pte. Woods 48236
Danielski, John J..........35478 Parkdale, Livonia 48150
Danto, Bruce L..........466 Fisher Bldg., Detroit 48202
Danz, George W...........1539 Ford, Wyandotte 48192
Daoust, Patrick H.......15520 Garfield, Allen Park 48101
Darling, Chas. E.........673 Fisher Bldg., Detroit 48202
Davidson, Harry O...2799 W. Grand Blvd., Detroit 48202
Davies, Windsor S.......28 W. Adams Ave., Detroit 48226

Davis, Herbert A......9901 Melbourne, Allen Park 48101
Davis, Jerome D.....19075 Middlebelt Rd., Livonia 48152
Dawson, W. A. (R)..........188 Lake Silver Dr. N.W., Winter Haven, Fl. 33880
Day, A. Jackson............3800 Woodward Ave., #406, Detroit 48201
Day, Francis T..............18540 Mack, Detroit 48236
Day, Jay C..............1016 Prof. Plaza, Detroit 48201
Day, Jorge H. 1787 Newcastle, Grosse Pointe Woods 48236
Day, Ruth S.........3790 Woodward Ave., Detroit 48201
Dayioglu, Vehbi...27560 Cherry Hill, Garden City 48135
de Aenlle, Eliodoro........29022 Merrick, Warren 48092
Dean, Carleton R. (M)..............Region 11, HEW, 26 Federal Plaza, New York, N. Y. 10007
Dean, George A.........19309 Greenfield, Detroit 48235
De Busk, Roger W........4160 John R St., Detroit 48201
Deering, Robt. J.....1359 Champaign, Lincoln Park 48146
DeFever, Cyril R.......19787 Mack Ave., Detroit 48236
De Groat, Albert F. (L)..1151 Taylor Ave., Detroit 48202
De Jongh, Edwin....Gen. Motors Building, Detroit 48202
Delaini, Stella M.....3011 W. Grand Blvd., Detroit 48202
De Lawrence, Betty J.............21576 Michigan Ave., Dearborn 48124
De Lawrence, Thomas............21576 Michigan Ave., Dearborn 48124
Del Giorno, Thos. E. (A)................Mecosta 49332
Delgiudice, P. A...........Grace Hospital, Detroit 48201
Del Valle, Francisco....3729 Fort St., Lincoln Park 48146
Del Valle, Mario..........19936 Packard, Detroit 48234
Denson, Andrew L. (A)..2224 Hazlewood, Detroit 48206
Deresz, Alphonse R.....4204 E. Outer Dr., Detroit 48234
Derleth, Paul E.....563 W. Oakridge Ave., Ferndale 48220
Derrick, C. F.......3677 Fort Street, Lincoln Park 48146
Deryke, Gilbert R.......35006 Wood Drive, Livonia 48154
De Smyter, Geo. C.......15527 E. Warren, Detroit 48224
DeSpelder, Ray E.............610 Blaine, Detroit 48202
DesRoberts, Yvon J.....18430 Mack Ave., Detroit 48236
Deuby, Owen J...15121 W. Seven Mile Rd., Detroit 48235
Devine, Herbert W.......22101 Moross Rd., Detroit 48236
Diakow, Lilian M.....1539 N. Line Rd., Wyandotte 48192
Dickenman, Robert C...........Detroit Memorial Hosp., Detroit 48226
Dicksheet, Sharad K.....23151 Van Dyke, Warren 48089
Dickson, Basil R......337 W. Grand Blvd., Detroit 48216
Dickson, Elias L., Jr.......17320 Livernois, Detroit 48221
Dickson, Leon A........5535 W. Chicago, Detroit 48204
Dickson, Mary D......................18424 Mack Ave., Grosse Pte. Farms 48236
Diebel, Nelson W........660 Cadieux Rd., Detroit 48230
Diekman, Fred C. 31815 Southfield Rd., Birmingham 48009
Dietze, Margaret R.........861 Monroe, Dearborn 48124
Dietzel, Hugo O. (R)................844 Hemlock Dr., San Carlos, Ca. 94070
Di Lella, Leonard L.....Henry Ford Hosp., Detroit 48202
Dill, Hugh L. (L)..16114 E. Warren Ave., Detroit 48224
Dill, J. Lewis................7387 Deep Run, Apt. 312, Birmingham 48010
Dillon, Thomas K. (A).....22250 Puritan, Detroit 48223
Di Loreto, Panfilo C.....285 Vincennes Pl., Detroit 48236
Di Maso, Gennaro J......20963 Kelly, East Detroit 48021
Dimond, Geo. E.........18401 Bretton Dr., Detroit 48223
Dipiero, Raniero............1800 Tuxedo, Detroit 48206
Dittmer, Edwin F.....18342 Mack Avenue, Detroit 48236
Dixon, Fredk. W.........245 S. Martha, Dearborn 48124
Dixon, Ray S. (L)........5001 Van Dyke, Detroit 48213
Doane, Clifford L...15041 East Seven Mile, Detroit 48205
Dodds, John C. (L)..18520 W. 7 Mile Rd., Detroit 48219
Dodenhoff, Chas. F.......18031 Kelly Rd., Detroit 48224
Dodrill, Forest D...Woodberry Dr., Bloomfield Hills 48013
Doering, Wendell R...17555 James Couzens, Detroit 48235
Doig, Victor F...............19676 Dale, Detroit 48219
Dolan, Edward A............1960 Hammond Lake Dr., Pontiac 48053
Dolega, Stanley F...15640 E. Warren Ave., Detroit 48224
Dolgoff, Sidney....15600 Michigan Ave., Dearborn 48126
Dolin, Simon..........28500 Bell Rd., Southfield 48075
Domjancic, John T..................Outer Drive Hosp., Lincoln Park 48146
Domzalski, Henry M...15252 Gratiot Ave., Detroit 48205
Donath, Rolf W.....719 New Center Bldg., Detroit 48202
Donovan, Eugene T. 13349 Michigan Ave., Dearborn 48126
Donovan, Richard S...17555 James Couzens, Detroit 48235
Dopico, Alfredo J. 6221 Merriman Rd., Garden City 48135
Doran, John H........15101 Plymouth Rd., Detroit 48227
Dorman, Jack..21701 W. 11 Mile Road, Southfield 48075
Dorostkar, M. G.........45101 Harmony, Belleville 48111
Dorsey, Edward C.......9000 E. Jefferson, Detroit 48214
Dorsey, John M.....65 Moss Avenue, Highland Park 48203
Doshi, Bhogilal C...........10448 Lincoln, Taylor 48180
Doty, Chester A. (L)............135 E. Maryland Ave., Phoenix, Az. 85012
Doub, Howard P. (L)............2799 W. Grand Blvd., Detroit 48202
Dougherty, Edw. A., Jr.........18241 W. McNichols Rd., Detroit 48219
Douglas, Clair L. (L).........1201 Richmond St., #807, London, Ont., Canada
Douglass, Robt. C.............23023 Orchard Lake Rd., Farmington 48024
Dovitz, Benj. W.....16820 Greenfield Ave., Detroit 48235
Downer, Ira G. (L)..8445 E. Jefferson Ave., Detroit 48214
Downes, Geo. O...........15062 Houston, Detroit 48205
Drake, Ellet H.........Henry Ford Hosp., Detroit 48202
Drapiza, Ruth L.....22231 W. Outer Dr., Dearborn 48124
Draves, Edward F..........19647 Joy Rd., Detroit 48228
Drazek, Jos. A..........14001 Greenfield, Detroit 48227
Dreyer, Joel......15800 W. McNichols Rd., Detroit 48235
Drouin, Michel (A).......V.A. Hospital, Dearborn 48121
Drozdowska, Z. J. F.......2357 Golfview Dr., Troy 48084
Drukker, Bruce H...Henry Ford Hospital, Detroit 48202
Drumm, John K........1420 St. Antoine St., Detroit 48226
D'Sena, Dorothy............33000 Palmer Rd., Wayne 48184
Dubin, Joseph J...2037 Medford Road, Ann Arbor 48104
Dubpernell, Martin S. (L)..4019 Gilbert St., Detroit 48210
Dubpernell, Robt. O....18595 Grand River, Detroit 48223
Dudek, John J.........19244 Grand River, Detroit 48223
Dumke, Paul R......2799 W. Grand Blvd., Detroit 48202
Duncan, James R...........5050 Joy Rd., Detroit 48204
Dunlap, Henry A...7815 Jefferson Ave. E., Detroit 48214
Dunn, Cornelius E. (L)..17230 Mack Ave., Detroit 48236
Dunn, John S. (A)...................368 Ridgemont, Grosse Pte. Farms 48236
Dupler, Gerald E...24234 Michigan Ave., Dearborn 48124
Durham, Everett W..............23100 Cherry Hill Rd., Dearborn 48124
Durham, Robt. (L).....Henry Ford Hosp., Detroit 48202
Dutcher, Dwight J..........711 S. Oxford, Detroit 48236
Duwe, Frank A.......25321 Five Mile Rd., Detroit 48239
Dwaihy, Paul J. (A).....14530 E. Warren, Detroit 48215
Dwyer, Francis W. (A).....15901 W. 9 Mile Rd., #314, Southfield 48075
Dyer, H. Lorne.........115 E. Dunlap, Northville 48167
Dykema, Rosemary M.....18424 Mack Ave., Detroit 48236
Dziuba, John F.....18901 W. Warren Ave., Detroit 48228
Dzul, Paul...........17800 E. 8 Mile Rd., Detroit 48236
Eades, Chas. C. (R)..649 Rivard Blvd., Grosse Pte. 48236
Easterly, Robt. L.....1404 Ford Avenue, Wyandotte 48192
Echt, Raymond J...........V.A. Hospital, Dearborn 48121
Eckhous, Arthur W........1015 Kales Bldg., Detroit 48226
Economy, Donald E.....18 W. Lane Ct., Dearborn 48124
Eder, Saml. J. (L)......19541 Cranbrook, Detroit 48221
Edgar, Irving I...1036 Dav. Whitney Bldg., Detroit 48226
Edmonds, Wm. N. (L)...........18525 Merriman Rd., Livonia 48152
Edmondson, Robt. B.....18501 Mack Ave., Detroit 48236
Edwards, C. Rupert L...........Detroit Receiving Hosp., Detroit 48226
Edwards, James G...17751 E. Warren Ave., Detroit 48224
Egan, Charles F.................Wyandotte Gen. Hosp., Wyandotte 48192
Eisenbrey, A. B.........1026 Fisher Bldg., Detroit 48202
Eisenstein, B.............459 Fisher Bldg., Detroit 48202
Eldredge, Edward F...18540 Mack Ave., Grosse Pte. 48236
Elie, Jean C......938 Dav. Whitney Bldg., Detroit 48226
Elliott, Jos. P., Jr........Henry Ford Hosp., Detroit 48202
Ellis, Frank R..........800 S. Lafayette, Dearborn 48124
Ellison, Leonard E...3800 Woodward Ave., Detroit 48201
Elman, Meyer J..........108 W. Hancock, Detroit 48201
Elson, Abraham L........Lafayette Clinic, Detroit 48207
Elvidge, Robt. J. (L)............2900 W. Grand Blvd., Detroit 48202

Emanuelsen, John.......14930 Grandville, Detroit 48223
Emmert, Herman C. (L)................4927 N. 34th, Arlington, Va. 22207
Endler, Gerhard C...................1394 Roslyn Rd., Grosse Pte. Woods 48236
Enfroy, Henri L...7421 W. Seven Mile Rd., Detroit 48221
Engel, Earl H...2336 Van Alstyne Blvd., Wyandotte 48192
Engstrom, Fredk. W.......2021 Monroe, Dearborn 48124
Engstrom, Ruby M.....1777 Culver Ave., Dearborn 48124
Eno, Laurel S.......212 Eastland Pr. Bldg., Detroit 48236
Ensign, Dwight C......Henry Ford Hosp., Detroit 48202
Eppler, William R...........20160 Mack, Detroit 48236
Epstein, Burton S........18215 Greenfield, Detroit 48235
Erickson, Eldon W................25750 W. Outer Dr., Lincoln Park 48146
Erickson, Miles A......1932 Ford Ave., Wyandotte 48192
Ericsson, Arthur D........Harper Hospital, Detroit 48201
Ericsson, Judith A...719 New Center Bldg., Detroit 48202
Erman, Jos. M........19530 Stratford Rd., Detroit 48221
Ermete, Sait D.....32633 Cherry Hill, Garden City 48135
Ernst, Reginald H...........5050 Joy Rd., Detroit 48204
Eschbach, Jos. W.....935 S. Military St., Dearborn 48124
Eskandari, Freydoon.3800 Woodward Ave., Detroit 48202
Eurs, Frank J.......................20485 Mack Ave., Grosse Pte. Woods 48236
Evans, Gomer P., Jr...1553 Woodward Ave., Detroit 48226
Evans, Jos. M..............16431 Harper, Detroit 48224
Evans, Tommy N.......18630 Fairway Dr., Detroit 48221
Ewing, Chas. H..........17120 E. Warren, Detroit 48224
Eyler, Wm. R.......2799 W. Grand Blvd., Detroit 48202
Eyres, Alfred E.......17800 E. Eight Mile, Detroit 48236
Fachnie, Harold L....17401 Greenfield Rd., Detroit 48235
Faello, Sebastian J...16840 E. Warren Ave., Detroit 48224
Fagan, James P..........987 E. Jefferson, Detroit 48207
Fagin, Irving D......18254 Livernois Ave., Detroit 48221
Fahim, Ramfis B.......14634 E. 7 Mile Rd., Detroit 48205
Falick, Mordecai L..........2257 Golfview, Troy 48084
Falk, Ira E............17411 Cherrylawn, Detroit 48221
Fallis, Lawrence S. (L)..........2799 W. Grand Blvd., Detroit 48202
Fandrich, Theodore S. (R)..........200 Miramar Ave., Montecito, Ca. 93103
Fanego, Luis R...........4496 Larme, Allen Park 48101
Farbman, Aaron A........14515 Kercheval, Detroit 48215
Farina, Angel M...........23550 Joy Rd., Detroit 48239
Farjardo, A. C..........Oakwood Hosp., Dearborn 48124
Farnam, Larry M., Jr........6200 Cadieux, Detroit 48224
Faunce, Sherman P......1824 Seminole St., Detroit 48214
Fea, John F......Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Maureen S...........Mt. Carmel Mercy Hosp., Detroit 48235
Fedeson, Theodore M..........Mt. Carmel Mercy Hosp., Detroit 48235
Feld, David.....15101 W. McNichols Rd., Detroit 48235
Feldkamp, Lee E..........360 N. Main, Plymouth 48170
Feldman, Irwin..........37380 Glenwood, Wayne 48184
Feldman, Nathanial L. (A)..........9420 S.W. 91st St. Miami, Fl. 33156
Feldman, Paul H.........16800 Greenfield, Detroit 48235
Feldstein, Martin Z............13345 W. McNichols Rd., Detroit 48235
Fellner, Wm. A...3 202 Gen. Motors Bldg., Detroit 48202
Fellows, William R.........3815 Pelham, Dearborn 48124
Fenech, Harold B. (L)...3790 Woodward, Detroit 48201
Fenner, Wm. G.......12454 E. Outer Dr., Detroit 48224
Fennessey, John F........512 Rivard, Grosse Pte. 48236
Fenton, James L. (M)..........1615 Birmingham Blvd., Birmingham 48009
Fenton, Meryl M...15901 W. 9 Mile Rd., Southfield 48075
Fenton, Russell F. (L).........15125 Grand River Ave., Detroit 48227
Fenton, Stanley C. (L)...15618 E. Warren, Detroit 48224
Fenton, Stuart V.............17600 Northland Park Ct., Southfield 48075
Fentress, Vance....308 Professional Plaza, Detroit 48201
Feringa, Philip J........20901 Moross Rd., Detroit 48236
Fernandez-Pena, C. E. (A)....Grace Hosp., Detroit 48201
Fernando, Oscar (A)......Grace Hospital, Detroit 48201
Ferrara, Richard J..................20045 Mack Ave., Grosse Pte. Woods 48236
Ferrara, Virginia M......18422 Woodward, Detroit 48203
Ferrari, Fulvio M...Northville St. Hosp., Northville 48167
Ferris, George N.........20001 Greenfield, Detroit 48235
Ferszt, Marion S.........15369 Grandville, Detroit 48223
Figiel, Leo S.............1500 Balmoral, Detroit 48203
Figiel, Steven J...........4160 John R St., Detroit 48201
Filkin, Lawrence E.......621 Fairbrook, Northville 48167
Fill, Leon..........2310 Cass, Exec. Suite, Detroit 48201
Finch, Alvis D...18000 Jas. Couzens Hwy., Detroit 48235
Finch, F. Sinclair........894 N. Renaud, Detroit 48236
Finck, Jerome H.........25841 Plymouth, Detroit 48239
Fine, Edward.....15901 W. 9 Mile Rd., Southfield 48075
Fine, Gerald...........Henry Ford Hosp., Detroit 48202
Fink, Saml...............10161 Burton, Oak Park 48237
Finkelstein, I. S..........17508 Dorset, Southfield 48075
Finkelstein, M. B.........18254 Livernois, Detroit 48221
Firestone, N.S. (M)............6672 Cottonwood Knoll, Birmingham 48010
Firnschild, Paul G......8 Shady Hollow, Dearborn 48124
Fischer, Arthur J.....36016 Five Mile Rd., Livonia 48154
Fischer, Fredk. J.........654 Fisher Bldg., Detroit 48202
Fishbein, Herbert L...987 E. Jefferson Ave., Detroit 48207
Fisher, Geo. S....1709 Dav. Whitney Bldg., Detroit 48226
Fisher, James M.....176 Merriweather, Grosse Pte. 48236
Fitzgerald, C. H...Wayne Co. Gen. Hospital, Eloise 48132
Fitzgerald, James M...15801 W. McNichols, Detroit 48235
Fitzpatrick, F. W..........17187 Schaefer, Detroit 48235
Flaherty, Henry J.............19600 W. McNichols Rd., Detroit 48219
Flaherty, Norman W..............24315 Fairmont Dr., Dearborn 48124
Flake, Thomas M.....13800 Livernois Ave., Detroit 48238
Flora, Wm. R.....17800 E. Eight Mile Rd., Detroit 48236
Flower, James A. (R)................1500 Via Soledad, Palm Springs, Ca. 92262
Floyd, William S................28505 Southfield Rd., Lathrup Village 48075
Fly, Marie N.........Oakwood Hospital, Dearborn 48124
Fogt, Robt. G.......316 Neff Road, Grosse Pointe 48230
Foley, Hugh S. (L).....1013 Haugh St., Dearborn 48124
Foote, John A....1336 Southfield Rd., Lincoln Park 48146
Ford, Geo. A. (L).....28 W. Adams Ave., Detroit 48226
Fordell, Frank S.....22159 W. Outer Dr., Dearborn 48124
Forgrave, Edward G....18520 Grand River, Detroit 48219
Forrer, Gordon R....20141 James Couzens, Detroit 48235
Fosnaugh, Robert P...23185 Timberline, Southfield 48075
Foster, E. Bruce....20905 Greenfield Rd., Southfield 48075
Foster, Owen C. (L)............1553 Woodward Ave., Detroit 48226
Foster, Wallace M..............13700 Woodward Ave., Highland Park 48203
Fountain, Charles W..2012 Monroe Blvd., Dearborn 48124
Fowler, Melvin E......247 E. Warren St., Detroit 48201
Fox, Thomas A., Jr......Henry Ford Hosp., Detroit 48202
Fraiberg, Paul L.......1454 Strathcona Dr., Detroit 48203
Frame, Boy......543 Lakepointe, Grosse Pte. Park 48230
France, Chas. J...17800 E. Eight Mile Rd., Detroit 48236
Frankel, Maurice A...............17000 W. Eight Mile, Southfield 48075
Franklin, John E.............4075 Ink Rd., Inkster 48141
Franzen, Nils A.......15360 Oakfield Ave., Detroit 48227
Frederickson, Geo. C.........7430 Second, Detroit 48202
Free, Harry W.......14300 W. McNichols, Detroit 48235
Freedman, John (R)....4853 Second Blvd., Detroit 48201
Freeman, Donald K.......881 Chalmers St., Detroit 48215
Freeman, Mable (L)..........1316 Dav. Broderick Twr., Detroit 48226
Freeman, Michael W....1810 Wellesley Dr., Detroit 48203
Freeman, Richard F...........525 Visger, Ecorse 48229
Freeman, Wilmer.....940 East 7 Mile Rd., Detroit 48203
Freid, Samuel.............17537 Parkside, Detroit 48221
Freier, Andrew A....18597 W. Ten Mile, Southfield 48075
Freier, Morton L......13051 Puritan Ave., Detroit 48227
Freitas, Eugene L.......St. Johns Hospital, Detroit 48236
Fremont, J. Courtney (A)..............55 Hall Place, Grosse Pte. Farms 48236
Friedlaender, Alex S...........10300 W. Seven Mile Rd., Detroit 48221
Friedlaender, Sidney..........10300 W. Seven Mile Rd., Detroit 48221
Friedlander, Joseph (A).......3776 Leslie, Detroit 48238
Friedman, David.........1333 Strathcona, Detroit 48203
Friedman, Hyman.....6742 Park Ave., Allen Park 48101

Friedman, Isidor H. (L)..3773 Second Ave., Detroit 48201
Friedman, Seymour......5132 Allen Rd., Allen Park 48101
Fromm, Stefan H...1400 Chrysler Freeway, Detroit 48207
Frost, Harold M.........Henry Ford Hosp., Detroit 48202
Frost, Richard G. (A)..............410 Hillcrest Ave., Grosse Pte. Farms 48236
Fryfogle, James D.......15901 W. Nine Mile Rd., #715, Southfield 48075
Fulgenzi, William R......1210 Kales Bldg., Detroit 48226
Fuller, Hugh M...404 David Whitney Bldg., Detroit 48226
Fulton, Wm. J. (R)..Wye Ferry, Queenstown, Md. 21658
Gagliardi, Carl A.......3516 Fort St., Lincoln Park 48146
Gajewski, John E.....Parke, Davis and Co., Detroit 48232
Galacz, Robert J. (M)............5089 Mansfield Ave., Royal Oak 48073
Galantowicz, H. C. (L)..7433 Mich. Ave., Detroit 48210
Galantowicz, Thos. H.....23601 Ford Rd., Dearborn 48128
Galdonyi, Laslo (L)..........2311 Dav. Broderick Twr., Detroit 48226
Galerneau, Darrel B. (L)..........144 S. Wilson Blvd., Mt. Clemens 48043
Gall, Henry........10531 Farmington Rd., Livonia 48150
Gallagher, Edw. W. (A)..18040 Fenmore, Detroit 48235
Gallagher, James P...14801 Southfield, Allen Park 48101
Gallant, Vincent J.........1414 Wellesley, Detroit 48203
Gallucci, Richard P.....23100 Cherryhill, Dearborn 48124
Galvin, John P...19959 Vernier Rd., Harper Woods 48236
Ganos, Thos...........6742 Park Ave., Allen Park 48101
Gans, Robert I....7310 W. Seven Mile Rd., Detroit 48221
Ganschow, John H.....1840 Holbrook Ave., Detroit 48212
Garcia, Remigio........Henry Ford Hosp., Detroit 48202
Gardner, Lawrence W...6071 W. Outer Dr., Detroit 48235
Gardner, Max L....19557 Mack Ave., Grosse Pte. 48236
Gariepy, Louis B...400 Southfield Rd., Birmingham 48009
Gariepy, Louis J. (L)...............400 Southfield Rd., Birmingham 48009
Gass, H. Harvey.........529 Fisher Bldg., Detroit 48202
Gaston, Herbert B.............7501 W. Morrow Circle, Dearborn 48126
Gatmaitan, Miguel G. (A)..Grace Hospital, Detroit 48201
Gaynor, Alex..........1755 E. 7 Mile Rd., Detroit 48203
Gehring, Harold W...........3535 W. 13 Mile, No. 507, Royal Oak 48072
Gehrke, August E. (R)..............24741 Tudor Lane, Franklin 48025
Geib, Ledru O. (L)..3528 Van Dyke Ave., Detroit 48214
Geitz, Wm. A. (R).....Box 1133, Boca Raton, Fl. 33432
Gelbach, Philip D.........2900 S. Fort St., Detroit 48217
Geoghegan, M. J. (M)......2435 Wendell, Detroit 48209
George, Alma R.............2424 Puritan, Detroit 48238
Gerisch, Robt. A...1217 Dav. Whitney Bldg., Detroit 48226
Gerondale, Elmond J. (L)........3001 W. Grand Blvd., Detroit 48202
Gibson, Dunbar P..............Box 1256, Detroit 48231
Gibson, Peter (M)...869 Fisher Building, Detroit 48202
Gibson, Wm.........3790 Woodward Ave., Detroit 48202
Giese, Fred W..........18526 Schoolcraft, Detroit 48223
Gigante, Nicola (L).........10 Peterboro, Detroit 48201
Gigliotti, David......16001 9 Mile Rd., Southfield 48075
Gilbert, Harold R........13146 Phelps, Wyandotte 48192
Giles, Conrad L................407 Northland Med. Bldg., Southfield 48075
Gillespie, Stephen M...23100 Cherry Hill, Dearborn 48124
Gilpin, Watson A...1539 Lockridge, Bloomfield Hills 48013
Gilreath, James L...........1800 Tuxedo, Detroit 48206
Gilroy, John..............Harper Hospital, Detroit 48201
Gimbel, Nicholas S..........1800 Tuxedo, Detroit 48206
Ginsberg, Harold I...15344 McNichols Rd., Detroit 48235
Girnius, Birute...............15439 Harper, Detroit 48224
Gitlin, Chas. (L)......2424 Oakman Blvd., Detroit 48238
Gittins, Perry C. (L)..............20905 Greenfield Rd., Southfield 48075
Givens, Donovan H., Jr.......726 Lathrup, Detroit 48202
Gizynski, Waldemar E...15357 Farmington, Livonia 48154
Glasgow, Gordon K. (R)............339 Chalfonte Ave., Grosse Pte. Farms 48236
Glazer, Walter S. (A)............1490 Charrington Rd., Birmingham 48010
Glement, Raymond D. (L).........16126 Woodring Ct., Livonia 48154
Glikman, Victor.....20131 James Couzens, Detroit 48235
Glowacki, Ben F. (L)...............8 Mile & Greenfield, Southfield 48075
Glowacki, Edward T.............20162 Wedgewood Dr., Grosse Pte. Woods 48236
Glowacki, Raymond M......961 Monroe, Dearborn 48124
Godley, Alegro J.........3790 Woodward, Detroit 48201
Goerke, Elmer A......36663 Goddard Rd., Romulus 48174
Goetz, Angus G. (L)............3800 Woodward, #406, Detroit 48201
Goins, Wm. F...1550 Charboneau Pl., #223, Detroit 48207
Goldberg, Arthur........20461 John R. St., Detroit 48203
Goldberg, Harry H. (L)..........2211 Woodward Ave., Detroit 48201
Golden, Alfred..26764 York Rd., Huntington Woods 48070
Goldfaden, Alfred.......9122 W. Fort St., Detroit 48209
Goldman, Aubrey....17191 James Couzens, Detroit 48235
Goldman, Perry........18050 Fairway Dr., Detroit 48221
Goldman, Robert T...Wayne County Hospital, Eloise 48132
Goldrath, Milton H................17000 W. 8 Mile Rd., Southfield 48075
Goldstein, Abe S.....19445 Gloucester Dr., Detroit 48203
Gollman, Maurice D...........17000 W. Eight Mile Rd., Southfield 48075
Gomez, Jorge (A)..........U.S.N. Hosp., F.P.O. Box 14, San Francisco, Ca. 96651
Gomley, Romuald H.....7220 Gratiot Ave., Detroit 48213
Gonzalez, Salvador......28 W. Adams St., Detroit 48226
Goodman, Maxwell M..................22265 Garrison, West Dearborn 48124
Goodman, Paul A.............Sinai Hosp., Detroit 48235
Goodman, Virgil P....................762 Bedford Rd., Grosse Pte. Park 48236
Goodwin, Warren W. 20101 James Couzens, Detroit 48235
Goodwin, William P......1616 Boston W., Detroit 48206
Gordon, Marvin....Detroit Memorial Hosp., Detroit 48226
Gordon, Seymour V. (A)............Beach Army Hosp., Fort Wolters, Tx. 76067
Gordon, Wm. E..........18058 Greenfield, Detroit 48235
Gorelick, Martin J...23901 Michigan Ave., Dearborn 48124
Goryl, Stephen V.........21501 Kelly, East Detroit 48021
Goss, Saml. B................10 Peterboro, Detroit 48201
Gostine, Edmond J.........9750 Chalmers, Detroit 48213
Gotham, James E..........3825 Brush St., Detroit 48201
Gotman, Abraham G.............987 E. Jefferson Ave., Detroit 48207
Gottlieb, Jacques S.......951 E. Lafayette, Detroit 48207
Gouda, Salah E. A.......28633 Hoover Rd., Warren 48093
Goux, Raymond S. (L)...........17566 Muirland Ave., Detroit 48221
Grabiel, Amado....................20145 Wedgewood, Grosse Pte. Woods 48236
Grace, Jos. M...31140 Huntley Square, Birmingham
Grady, Jos. A.........946 Three Mile Dr., Detroit 48230
Graham, John G., Jr...491 Lincoln Rd., Grosse Pte. 48236
Graham, Theodore N.........2424 Puritan, Detroit 48238
Granger, Francis L.....14160 Gratiot Ave., Detroit 48205
Granger, George R...........705 David Whitney Bldg., Detroit 48226
Grant, Abraham H...22454 Chatsford Cir., Southfield 48075
Grant, Heman E. (L)....Box 224, Babson Park, Fl. 33827
Gratton, Henri L. (L)..76 W. Adams Ave., Detroit 48226
Gratton, J. Paul V.....Henry Ford Hosp., Detroit 48202
Graves, James H...63 Kercheval, Grosse Pte. Farms 48236
Gray, Howard O............5050 Joy Rd., Detroit 48204
Green, Edward W....2799 W. Grand Blvd., Detroit 48202
Green, Ellis R. (L).....5172 Scotten Ave., Detroit 48210
Green, Henry L.........17214 Jeanette, Southfield 48075
Green, Lewis..........13000 Grand River, Detroit 48227
Green, Milton M...17000 W. 8 Mile Rd., Southfield 48075
Green, Nelson W.................31815 Southfield Rd., Birmingham 48009
Green, Thomas, Jr...........5050 Joy Rd., Detroit 48204
Greenberg, Jack R............15821 W. Seven Mile Rd., Detroit 48235
Greenberg, Julius J.....5328 W. Outer Dr., Detroit 48235
Greenberg, Morris Z.......9105 Van Dyke, Detroit 48213
Greenberg, Stanley....20905 Greenfield, Southfield 48075
Greene, John B.....2179 W. Grand Blvd., Detroit 48208
Greene, Thomas J.......1054 Fisher Bldg., Detroit 48202
Greenlee, Wm. T. (L)...15053 Maddelein, Detroit 48205

Greenslit, Frank S.............U. S. Vets. Admin. Hosp., Dearborn 48121
Greer, Clarence W. (A)......2642 Arndt, Detroit 48207
Gregory, Gertrude B...Ford Tractor Plant, P.O. Box 3622, Highland Park 48203
Gregory, Louis J.........47 Webber Place, Detroit 48236
Griffin, Robert J..........17401 Mack Ave., Detroit 48224
Griffiths, Sydney J.....15400 Plymouth Rd., Detroit 48227
Grifka, Thomas J.....1400 Chrysler Expwy., Detroit 48207
Grimaldi, Gregory J. (A)...2983 Seminole, Detroit 48214
Grinstein, Alexander.....18466 Wildemere, Detroit 48221
Grishkoff, M. A.........2201 E. Jefferson, Detroit 48207
Griva-Lizlovs, Sylvia..29901 Ford Rd., Garden City 48135
Griz, John...........3815 Pelham Rd., Dearborn 48124
Grob, Otto (A).................900 Calle Delosamigos, Santa Barbara, Ca. 93105
Gronemeyer, Wm. H.........1800 Tuxedo, Detroit 48206
Grose, Frederick J...19350 W. 7 Mile Rd., Detroit 48219
Grossman, Solomon C............26339 Woodward Ave., Huntington Woods 48070
Gudes, David S.........1080 Fisher Bldg., Detroit 48202
Guerrero, Jose (L)......13700 Woodward, Detroit 48203
Guevara, Omar......29901 Ford Rd., Garden City 48135
Guevara, Walter..........Lafayette Clinic, Detroit 48207
Guidot, Julian M.....13345 W. McNichols, Detroit 48235
Guimaraes, Abilio S. (L)...........7301 Schaffer Hwy., Dearborn 48126
Guinan, Geo. E. (L)......5012 Howe Rd., Wayne 48184
Guindi, Mounir F.........23580 Geneva, Oak Park 48237
Guindi, Sami F.........1080 Fisher Bldg., Detroit 48202
Guise, Edwin R., Jr...Henry Ford Hospital, Detroit 48202
Gulick, Arthur E.............4160 John R, Detroit 48201
Gurdjian, Elisha S...1553 Woodward Ave., Detroit 48226
Gurskis, Eugenia E.......504 Kales Bldg., Detroit 48226
Gutow, Benjamin R..........20867 Mack, Detroit 48236
Guyon, Jos. F.........Wyandotte Hosp., Rehab. Center, 2331 Van Alstyne Blvd., Wyandotte 48192
Guyton, Jack S......2799 W. Grand Blvd., Detroit 48202
Hacker, Elaine M.........763 Fisher Bldg., Detroit 48202
Haddad, Benjamin F...........1010 Mich. Mutual Bldg., Detroit 48226
Haddad, Elias D.....14636 E. Seven Mile, Detroit 48205
Hadesman, Donald.......985 E. Jefferson, Detroit 48207
Hadjimihaloglu, B. S...2429 E. Milwaukee, Detroit 48211
Haefele, Leslie P.....29108 Ford Rd., Garden City 48135
Hagermoser, H. H...412 Eastland Ctr. Bldg., Detroit 48236
Haidostian, B. H.......18456 Grand River, Detroit 48223
Haines, Ellen R.............525 Seyburn, Detroit 48214
Haitinger, K. S.......22175 Thorofare, Grosse Ile 48138
Haking, Leonard....14014 E. 7 Mile Rd., Detroit 48205
Halekas, G. Peter 21727 Mack Ave., St. Clair Shores 48080
Haley, William A......8339 Mack Avenue, Detroit 48214
Hall, Arch H.............3790 Woodward, Detroit 48201
Hall, C. Robert (A).Detroit General Hosp., Detroit 48226
Hall, E. Walter (L)..14189 Rosemont Rd., Detroit 48223
Hall, Ralph E. (L)..Drummond Island, Drummond 49726
Hall, Richard H.............828 Fisher Bldg., Detroit 48202
Hall, Winthrop D...5237 Oakman Blvd., Dearborn 48126
Hallen, Leonard J........1335 Nicolet Pl., Detroit 48207
Hamaker, Ronald C. (A)..........1721 Gardenia, #11, Royal Oak 48067
Hamburg, Robt. H............1515 Dav. Whitney Bldg., Detroit 48226
Hamburger, Albert C...13345 W. McNichols, Detroit 48235
Hamburger, Stuart W.............18400 Schaefer Hwy., Detroit 48235
Hamil, Brenton M......Henry Ford Hosp., Detroit 48202
Hammer, Edwin J.......16616 Mack Ave., Detroit 48224
Hammer, Roy W......11455 E. McNichols, Detroit 48234
Hammond, Arthur E. (L).........1553 Woodward Ave., Detroit 48226
Hammond, James L. (L)..............1006 Morse St., Oceanside, Ca. 92054
Handel, Jack E....Detroit Memorial Hosp., Detroit 48226
Hansen, John W. (R)...........715 W. Michigan Ave., Jackson 49201
Hanyi, Karl..........7645 Thornwood, Plymouth 48170
Hardstaff, R. John (L)...648 Neff Rd., Grosse Pte. 48230
Hardt, Barbara A......1301 Orleans, #303, Detroit 48207
Hardy, Clarence M.......23019 Ecorse Rd., Taylor 48180
Hardy, Geraldine M.................19707 Mack Ave., Grosse Pte. Woods 48236
Hardy, Warren G...801 Dav. Whitney Bldg., Detroit 48226
Harelik, Ely W. (L).............Det. House Correction, Plymouth 48170
Harkaway, Roman W.....19125 Van Dyke, Detroit 48234
Harley, Garth H.......451 Golfcrest Dr., Dearborn 48124
Harley, Louis M...4100 W. McNichols Rd., Detroit 48221
Harm, Winfred B. (L)...........16150 Oxley, Apt. 101, Southfield 48075
Harmon, Edwin L...................745 Bedford Rd., Grosse Pte. Park 48230
Harmon, Walter, Jr...13700 Woodward Ave., Detroit 48203
Harnett, R. W. F.........529 Fisher Bldg., Detroit 48202
Harper, James H...Kirwood General Hosp., Detroit 48238
Harper, Jesse T...1110 Dav. Whitney Bldg., Detroit 48226
Harrington, F. L...15901 W. 9 Mile Rd., Southfield 48075
Harris, A. D...............12815 Linwood, Detroit 48238
Harris, Donald M...517 E. Roosevelt, Battle Creek 49017
Harris, Harcourt G......9141 Dexter Blvd., Detroit 48206
Harris, Harold H. (R)................1221 Drew, C-1, Clearwater, Fl. 33315
Harris, Ivor D....1245 David Whitney Bld., Detroit 48226
Harrity, William A.............302 Eastland Prof. Bldg., Detroit 48236
Hart, Charles E.....23845 Van Dyke, Center Line 48015
Hart, John C. (A)...........9341 Moffat, Detroit 48213
Hart, Zwi H.........800 N. Gulley Rd., Dearborn 48128
Hartkop, Henry H.......20055 Mack Ave., Detroit 48236
Hartquist, Robt. J........1495 Fort St., Wyandotte 48192
Hartzell, John B.....7815 Jefferson Ave. E., Detroit 48214
Hartzell, John M........7815 E. Jefferson, Detroit 48214
Hasley, Clyde K. (L).........2320 N. Lasalle Gardens, Detroit 48206
Hasley, Danl. E. (R)....16512 Shaftsburg, Detroit 48219
Hassett, Gerard R.....St. Mary's Hospital, Livonia 48151
Hassig, Walter W.......20914 Kelly, East Detroit 48021
Hastings, Orville J......15744 Harper Ave., Detroit 48224
Haszczyc, Vladimir A....3329 Yemans, Hamtramck 48212
Hathaway, Hubert R. (A)..........154 Englewood Rd., Springfield, Oh. 45504
Haubrich, Wm. S.......Henry Ford Hosp., Detroit 48202
Hause, Glen E.........18520 Grand River, Detroit 48223
Hauser, I. Jerome........7411 Third Ave., Detroit 48202
Hauser, John E.............405 Northland Med. Bldg., Southfield 48075
Hauser, Maurice J. (A)...7411 Third Ave., Detroit 48202
Hawash, Raouf R...25701 Joy Rd., Dearborn Hgts. 48127
Hawkins, James W. (L)..........3885 Prudence Drive, Sarasota, Fl. 33580
Hawtof, David B..15901 W. 9 Mile Rd., Southfield 48075
Hayden, Royal C., Jr...Henry Ford Hospital, Detroit 48202
Hayes, Allen L..........17431 Greenfield, Detroit 48235
Hazen, Roy S.........15121 W. 7 Mile Rd., Detroit 48235
Heath, Leonard P....1553 Woodward Ave., Detroit 48226
Heavner, Lyle E.....17700 Mack Ave., Grosse Pte. 48224
Heenan, Theopilus H..............1553 Woodward Ave., Detroit 48226
Heideman, Louis E...3800 Woodward Ave., Detroit 48001
Heil, Edward R........24111 Southfield, Southfield 48075
Heins, Marilyn..........747 Lakeland, Grosse Pte. 48236
Heldt, Richard F.....1951 Monroe Blvd., Dearborn 48124
Heldt, Thos. J. (L)..17 Poplar Park, Pleasant Ridge 48069
Helman, Norman (M)...............3828 S. Yosemite, Denver, Co. 80237
Hendelman, Manuel H.......17141 Hayes, Detroit 48205
Henderson, Allison B....9041 Dexter Blvd., Detroit 48206
Henderson, Arthur B. (L).........946 Beaconsfield Rd., Grosse Pte. Park 48230
Henderson, Chas. W...20905 Greenfield, Southfield 48075
Henderson, Frederic C...18601 Mack Ave., Detroit 48236
Henderson, Hugh W.....18601 Mack Ave., Detroit 48236
Henderson, Leslie T. (L)..18101 E. Warren, Detroit 48224
Henderson, Wm. E. (L)..18601 Mack Ave., Detroit 48236
Hendra, Alan K...........15540 Harper, Detroit 48224
Hendrie, Hugh C...................70 Thatcher Dr., Ft. Garry, Manitoba, Canada
Henig, Fred N....7605 W. Seven Mile Rd., Detroit 48221
Henkin, Raymond......17228 Shervilla, Southfield 48075
Henkin, Wm. A.........18215 Greenfield, Detroit 48235
Hennessey, Alan T.......Oakwood Hosp., Dearborn 48121

Henrich, Laurence E. (L)........18239 W. Seven Mile., Detroit 48219
Henry, Robert C..........1 Lafayette Pl., Detroit 48207
Herbst, Harold B...7282 Riverstone Rd., Birmingham 48010
Hergt, Klaus......10909 W. Jefferson, River Rouge 48218
Hernandez, Hugo R. (A).........Northville State Hosp., Northville 48167
Herrero, Eduardo M...21913 Canterbury, Grosse Ile 48138
Herrero, Eduardo U...21845 Canterbury, Grosse Ile 48138
Herrold, Rose E. (L)..1277 E. Grand Blvd., Detroit 48211
Herschelmann, Roy F....3343 Gratiot Ave., Detroit 48207
Hershey, Ernest A., Jr..........641 Dav, Whitney Bldg., Detroit 48226
Hertzler, Jack H.....3011 W. Grand Blvd., Detroit 48202
Herwick, John T.....2799 W. Grand Blvd., Detroit 48202
Hess, Joseph W. (A)..1401 Rivard St., Wayne State Univ., Detroit 48207
Hessburg, Philip C.....Henry Ford Hosp., Detroit 48202
Heyman, Louis F.............19009 W. Seven Mile Rd., Detroit 48219
Heyner, C. S...............15901 W. 9 Mile Rd., #400, Southfield 48075
Heyner, Fredk. J...........15901 W. 9 Mile Rd., #400, Southfield 48075
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 48204
Hicks, Fredk. G......1000 Westwood, Birmingham 48009
High, Robert H.........Henry Ford Hosp., Detroit 48202
Higuera, J. Gilberto..13700 Woodward Ave., Detroit 48203
Hill, Edward J., Jr.............949 Dav. Whitney Bldg., Detroit 48226
Hill, George C.............5050 Joy Rd., Detroit 48204
Hill, Raymond D......14551 Southfield, Allen Park 48101
Hill, Welford T..........6303 Mack Ave., Detroit 48207
Hillenberg, Sidney J...19350 W. 7 Mile Rd., Detroit 48219
Hiller, Glenn I.............15901 W. 9 Mile Rd., #610, Southfield 48075
Hillyer, John W.........3700 West Road, Trenton 48183
Hilton, Wm. E. (L)........5013 Harding, Detroit 48213
Hinchman, D. F....10865 Farmington Rd., Livonia 48150
Hipps, Chauncey J...2605 West Grand Blvd., Detroit 48208
Hirsch, Leo J.................1190 E. Twelve Mile Rd. Madison Heights 48071
Hirsch, Lore...........212 S. Melborn, Dearborn 48124
Hirschfeld, A. H.........3790 Woodward, Detroit 48201
Hoagland, F. L. (A)..716 E. Grand Blvd., Detroit 48207
Hobbs, Donald V.................27305 Southfield Rd., Lathrup Village 48075
Hochman, Morton M...16633 Plymouth Rd., Detroit 48227
Hodges, Jason......26401 Harper, St. Clair Shores 48081
Hodgkinson, Chas. P.............17546 Meadwood Ave., Lathrup Village 48075
Hoffer, Thos...........5825 Allen Rd., Allen Park 48101
Hoffman, Ben G........19545 Shrewsbury, Detroit 48221
Hoffman, Edward A...7615 W. Vernor Hwy., Detroit 48209
Hoffman, Edwin S. (R)..........8106 E. Jefferson Ave., Detroit 48214
Hoffman, Harry Y.............15085 E. Seven Mile Rd., Detroit 48205
Hoffman, Henry A.....10015 E. Outer Dr., Detroit 48224
Hoffman, Louis............21701 W. 11 Mile Rd., #9, Southfield 48075
Hoffman, Milton C.......18555 E. Warren, Detroit 48236
Hogikyan, Azat..16901 W. McNichols Rd., Detroit 48235
Holbrook, James M. (A)..3509 Meckl Dr., Warren 48092
Holdredge, Jean M...3011 W. Grand Blvd., Detroit 48202
Hollander, Abraham J.............14327 Michigan Ave., Dearborn 48126
Hollinger, F. Wayne..8265 Gen. Mtrs. Bldg., Detroit 48202
Hollis, Henry B..............6809 Sirena, Detroit 48210
Holloway, Horace R.......12840 Linwood, Detroit 48238
Holloway, Janet L...........7430 Second, Detroit 48202
Hollowell, M. L......10720 W. 7 Mile Rd., Detroit 48221
Holmes, George F.....14729 Champaign, Allen Park 48101
Holt, Chas. J., Jr.......1210 S. Oxford, Grosse Pte. 48236
Holt, Henry T..............5050 Cass St., Detroit 48202
Holt, W. S., Jr.........Mt. Carmel Hosp., Detroit 48235
Homeister, Eugene A..........12925 Pennsylvania Ave., Wyandotte 48192
Honet, Joseph C...........Sinai Hospital, Detroit 48235
Honhart, Fred L. (L)...........1405 Berkshire Road, Grosse Pte. 48230

Hopkins, Andrew J........4407 Roemer, Dearborn 48126
Hopkins, George C............3183 Mack, Detroit 48207
Hopkins, Scovell M...........910 Dav. Broderick Twr., Detroit 48226
Horkins, Earl J.........32300 Schoolcraft, Livonia 48154
Horn, Robt. C., Jr....2799 W. Grand Blvd., Detroit 48202
Hornbeck, Robert J...31500 Schoolcraft Rd., Livonia 48150
Horny, Hugo O........619 Barrington Rd., Detroit 48230
Horrell, Eugene D.......1408 Kales Bldg., Detroit 48226
Horton, Reece H...............606 Northland Med. Ctr., Southfield 48075
Horvath, James J....1553 Woodward Ave., Detroit 48226
Horvitz, Victor S......18400 Schaefer Hwy., Detroit 48235
Hotchkiss, Loris M........33220 W. 7 Mile, Livonia 48152
Howard, Philip J.......Henry Ford Hosp., Detroit 48202
Howard, William K..........1800 Tuxedo, Detroit 48206
Howell, Bert F.........10800 Whittier Rd., Detroit 48224
Howell, James T.....2799 W. Grand Blvd., Detroit 48202
Howes, Homer A. 1515 Dav. Whitney Bldg., Detroit 48226
Howlett, Howard T.......868 Fisher Bldg., Detroit 48202
Hoyos, Pedro G....................6085 Campus Dr., Dearborn Hghts. 48127
Hromadko, Louis (L)...1053 Fisher Bldg., Detroit 48202
Hubbard, John P., Jr. (L)......14620 E. Seven Mile Rd., Detroit 48205
Huber, Philip J...........1724 Bassett, Royal Oak 48067
Hudson, J. Stewart (L)................319 Fisher Rd., Grosse Pte. 48230
Hudson, Wm. A. (L).....Hudsonakers, Jasper, Ar. 72641
Hudspeth, E. Rae........763 Fisher Bldg., Detroit 48202
Huebl, Hubert C. (A)...............1212 Shatto Street, Los Angeles, Ca. 90017
Huegli, Wilfred A...16840 E. Warren Ave., Detroit 48224
Huggins, H. Horne..........8355 Gratiot, Detroit 48213
Hughes, Calvin H....19959 Vernier, Harper Woods 48236
Hughes, John A. (A)......4407 Roemer, Dearborn 48126
Hughett, Arthur L....19959 Vernier, Harper Woods 48236
Hulick, Archie G............1600 Tuxedo, Detroit 48206
Hull, Leroy W. (L).....6364 Cowell Rd., Brighton 48116
Hullerman, Hugo V.....Children's Hospital, Detroit 48202
Hume, H. Ross, Jr..........3800 Woodward Ave., #406, Detroit 48201
Humes, James J.........St. John Hospital, Detroit 48236
Huminski, Thaddeus S.............19244 Van Dyke Ave., Detroit 48234
Hummel, Arthur R.....1020 3 Mile Rd., Grosse Pte. 48236
Hunt, Theodore H...19431 Van Dyke Ave., Detroit 48234
Hunt, Verne G. (L)..1553 Woodward Ave., Detroit 48226
Hunter, Donald G.......3245 E. Jefferson, Detroit 48207
Hunter, Robert B.......Henry Ford Hosp., Detroit 48202
Husband, Chas. W. (L)...........14500 W. McNichols, Detroit 48235
Husband, Raymond C..............14500 W. McNichols, Detroit 48235
Hutchins, M. Colton..3011 W. Grand Blvd., Detroit 48202
Hyatt, Jarvis M.....22340 Michigan Ave., Dearborn 48124
Hyde, Fredk. W., Jr........Grace Hospital, Detroit 48201
Hyland, John R..............17200 Mack, Detroit 48224
Hysni, Aliqemal....8031 W. Vernor Hwy., Detroit 48209
Iacobell, Peter H.........19300 Van Dyke, Detroit 48234
Iacobellis, M.......22159 W. Outer Drive, Dearborn 48124
Ice, Garnet T........8401 Woodward Ave., Detroit 48202
Iglesias, Luis J. (A)..............3535 W. 13 Mile Rd., Royal Oak 48072
Igna, Eli J..........2799 W. Grand Blvd., Detroit 48202
Ignagni, Antonio.........21470 Sloan Dr., Detroit 48207
Imamoglu, Kamil (A)............1400 Chrysler Expwy., Detroit 48207
Imperio, Napoleon C..............22231 W. Outer Dr., Dearborn 48124
Indenbaum, Samuel..18400 Schaefer Hwy., Detroit 48235
Ine, Myung Yul............1800 Tuxedo, Detroit 48206
Ingberg, Harry O.............261 Brady, Detroit 48201
Irvin, Earle A...Ford Motor Co. America, Dearborn 48121
Irwin, Wm. A........16001 9 Mile Rd., Southfield 48075
Isaacson, Arthur (L).....18989 San Juan, Detroit 48221
Isaacson, Harold E.....15361 Plymouth Rd., Detroit 48227
Isaacson, Jo. D.......................26008 Pembroke, Huntington Woods 48070
Ishac, F. F...........38241 Southfarm, Northville 48167
Israel, Barney B.........663 Fisher Bldg., Detroit 48202

Itkin, H. David..........2900 S. Fort St., Detroit 48217
Iwata, Herbert T........7611 Patton Ave., Detroit 48228
Izner, Bernice............16500 North Park Dr., #410, Southfield 48075
Izner, Sanford M...............7946 Ivanhoe St., #302, La Jolla, Calif. 92037
Jablonski, Donald V...3800 Woodward Ave., Detroit 48201
Jacknow, David..........60 W. Hancock, Detroit 48201
Jackson, Franklin R..........2424 Puritan, Detroit 48238
Jackson, Winston B.........2425 Oakman, Detroit 48238
Jacobs, David M.....10601 W. 7 Mile Rd., Detroit 48221
Jacobs, Howard.........18241 Greenfield, Detroit 48235
Jacobson, Lyle F.........5224 St. Antoine, Detroit 48202
Jacobson, Saml. D...Wayne Co. Genl. Hosp., Eloise 48132
Jacobus, Wayne N...20055 Mack Ave., Grosse Pte. 48236
Jaconette, J. R....Mt. Carmel Mercy Hosp., Detroit 48235
Jaeger, Grove A...........11711 Minden, Detroit 48205
Jaekel, Clarence N. (L)..........1086 E. Grand Blvd., Detroit 48207
Jaffar, Donald J............15901 W. 9 Mile Rd., #514, Southfield 48075
Jaffe, Harold W...1706 David Whitney Bl., Detroit 48226
Jaffe, Jacob......11740 Wilshire, Los Angeles, Ca. 90025
Jaffe, Louis..............18662 Muirland, Detroit 48221
Jahsman, Wm. E. (R).........501 Mandalay Ave. G-18, Clearwater Beach, Fla. 33515
Jakacki, Richard Wm.....36157 Sherwood, Livonia 48154
Jamieson, Thos. J. (L)...2058 Ferris, Lincoln Park 48146
Janicki, Natalia J.............Eloise Hosp., Eloise 48132
Jarvis, Harold F..............360 Moross, Detroit 48236
Jasion, Lawrence J. (A).....11945 Payton, Detroit 48224
Jaynes, Richard V.....29901 Ford Rd., Garden City 48135
Jeffries, Benj.....19959 Vernier Rd., Harper Woods 48236
Jend, Wm., Jr............1365 Cass Ave., Detroit 48226
Jenkins, Elwood A.............610 Dav. Whitney Bldg., Detroit 48226
Jennings, Chas. G...356 Hillcrest, Grosse Pte. Farms 48236
Jensen, Viggo W...........17850 Maumee, Detroit 48230
Jevons, William H...8425 Twelve Mile Rd., Warren 48093
Jewell, F. C............7220 Gratiot Ave., Detroit 48213
Jewell, John S...2021 Monroe, Suite 203, Dearborn 48124
Jewell, Marvin R.......Childrens Hospital, Detroit 48202
Jocz, Marion W.........945 Trombley Rd., Detroit 48230
Jodar, Emery O.........15760 Mack Ave., Detroit 48224
Jodar, Loyal W.........18412 Mack, Grosse Pte., 48236
John, Hubert R. (L)..20905 Greenfield, Southfield 48075
Johnson, Aran S.....................642 Blairmoor Ct., Grosse Pte. Woods 48236
Johnson, Arthur J.....Henry Ford Hospital, Detroit 48202
Johnson, Gage............2785 S. Fort St., Detroit 48217
Johnson, Rodger L...1369 Westwood, Birmingham 48009
Johnson, Thos. D......18530 Grand River, Detroit 48223
Johnson, Verne E.....2051 Monroe Ave., Dearborn 48124
Johnson, Vernon P..................21327 Harper Ave., St. Clair Shores 48080
Johnson, Wilbur E..........14654 Gratiot, Detroit 48205
Johnson, Wm. H. M. (L) 7157 63 Michigan, Detroit 48210
Johnston, Everett V. (L)............30130 Bristol Lane, Birmingham, 48010
Johnston, Herbert C.........Ford Motor Co., Rouge Pl., 3001 Miller Rd., Dearborn 48121
Johnston, Jos. A. (L)...Henry Ford Hosp., Detroit 48202
Johnston, Wm. E. (L)............3011 W. Grand Blvd., Detroit 48202
Johnstone, Benj. I. (L)...............31 Oakland Park, Pleasant Ridge 48069
Joinville, Euclide V. (L)..1202 Stroh Bldg., Detroit 48226
Jones, Arnold M..........3706 Sturtevant, Detroit 48206
Jones, Don P.........Wayne State Univ., Detroit 48207
Jones, G. Richard.......18412 Mack Ave., Detroit 48236
Jones, Roy D. (L).....10234 Puritan Ave., Detroit 48238
Jones, Wm. J.........8209 Allen Rd., Allen Park 48101
Joos, Thad. H........20340 Harper, Harper Woods 48236
Jordan, Prescott, Jr.......5224 St. Antoine, Detroit 48202
Jordan, R. Gerald.......12410 Van Dyke, Detroit 48234
Joseph, Ramon R....Wayne Co. Gen. Hosp., Eloise 48132
Joshi, Daya P.........987 E. Jefferson Ave., Detroit 48207
Joyce, Stanley J. (L)..........2040 W. McNichols Rd., Detroit 48203
Joyrich, Myron H..........Sinai Hospital, Detroit 48235
Juliar, Benj..........17305 Muirland Ave., Detroit 48221
Juliar, Joseph F...........17526 Oak Dr., Detroit 48221
Juncker, John B. (M)...Oakwood Hosp., Dearborn 48124
Jungwirth, R. V...19350 W. McNichols Rd., Detroit 48219
Kackley, James E............18495 Mack, Detroit 48236
Kain, Thomas R.....3245 E. Jefferson Ave., Detroit 48207
Kaine, Henry D......3011 W. Grand Blvd., Detroit 48202
Kalayjian, Bernard S...30676 Harlincin Ct., Franklin 48025
Kalichman, Nathan.......19304 Wyoming, Detroit 48221
Kallenbach, Rudolph W....388 Inkster Rd., Inkster 48141
Kallet, Herbert I. (L)....651 Fisher Bldg., Detroit 48202
Kallet, Maerit B.............1800 Tuxedo, Detroit 48206
Kallman, David (L)..2351 W. Grand Blvd., Detroit 48208
Kallman, Leo.......2351 W. Grand Blvd., Detroit 48208
Kallman, Reuben R...2631 Woodward Ave., Detroit 48201
Kambouris, Angelos A...........744 Dav. Whitney Bldg., Detroit 48226
Kamil, Richard S........14438 McNichols, Detroit 48235
Kandel, Robert F.......Henry Ford Hosp., Detroit 48202
Kane, Archibald V............Box 1108, Northland Ctr., Southfield 48075
Kansa, Selma...........19431 Van Dyke, Detroit 48234
Kantor, Sheldon M.........19207 Schaefer, Detroit 48235
Kapetansky, Don I........17376 Schaefer, Detroit 48235
Kapetansky, Nathan J.......17376 Schaefer, Detroit 48235
Kaplita, Walter A....................60 Fontana Lane, Grosse Pte. Shores 48236
Kapphahn, K. H........Henry Ford Hosp., Detroit 48202
Kapreilain, Michael................189 Townsend # 210, Birmingham 48011
Karabeyoglu, Turgut..............Northville State Hosp., Northville 48167
Karadeloglou, B.........817 Virginia Park, Detroit 48202
Karamatas, Philip C...10822 W. Warren, Dearborn 48126
Karch, Saul..............18080 Muirland, Detroit 48221
Kasabach, Harry Y...1553 Woodward Ave., Detroit 48226
Kashtan, Harry A.....15201 W. McNichols, Detroit 48235
Kasper, Jos. A. (L)..................1011 Cadieux Rd., Grosse Pte. Park 48230
Kaspor, Albert J........20901 Moross Rd., Detroit 48236
Kass, Arnold......1316 David Stott Bldg., Detroit 48226
Katz, Lawrence..........987 E. Jefferson, Detroit 48207
Katz, Martin.......12794 Veronica Dr., Southgate 48192
Katzman, Irving S.........848 Fisher Bldg., Detroit 48202
Kaufman, Jack H........17421 Greenfield, Detroit 48235
Kaufman, Louis W...10326 W. Seven Mile, Detroit 48221
Kaufman, William H............10149 Michigan Ave., Dearborn 48126
Kawchak, James.......Ford Motor Co., Dearborn 48121
Kawecki, Lucian.....................10734 Hart Ave., Huntington Woods 48070
Kawel, Conrad A., Jr.............10955 Farmington Rd., Livonia 48150
Kayi, Cengiz.....Northville State Hosp., Northville 48167
Kazdan, Morris.......4619 Allen Road, Allen Park 48101
Keemer, Edgar B. Jr...........1111 David Whitney Bldg., Detroit 48226
Kehoe, Henry J........15252 Gratiot Ave., Detroit 48205
Keith, Rachel H. C. B.......5050 Joy Rd., Detroit 48204
Kelin, Maximilian..................5133 Nob Hill Ct., Bloomfield Hills 48013
Kelley, Frank J..........853 Fisher Bldg., Detroit 48202
Kelly, A. P., Jr.........Henry Ford Hosp., Detroit 48202
Kelly, Edward W., Jr......156 Harmon St., Detroit 48202
Kelly, John J.........14729 Champaign, Allen Park 48101
Kelly, L. J.................14015 Gratiot, Detroit 48205
Kelmenson, Victor A........7356 12th St., Detroit 48206
Kelson, Malcolm J...........1045 Harvard, Detroit 48230
Kennary, James M......4900 Cadieux Rd., Detroit 48224
Kennary, James M., Jr...4900 Cadieux Rd., Detroit 48224
Kennedy, Donald J...............410 North Shore Drive, St. Clair Shores 48080
Kernath, James E.....15101 Southfield, Allen Park 48101
Kernick, Melvin O..............13700 Woodward Ave., Highland Park 48203
Kerwin, George R...22149 Chatsford Cir., Southfield 48075
Kessel, Karl J........21421 Kelly Rd., East Detroit 48224
Kessler, Chas.............18241 Greenfield, Detroit 48235
Keyes, John W.........Henry Ford Hosp., Detroit 48202
Killins, Chas. G.........8100 E. Jefferson, Detroit 48214
Kimberlin, K. K., Jr...11110 Morang Drive, Detroit 48224
King, Edward D. (L)......270 Rivard, Grosse Pte. 48230

King, Melbourne J...5435 W. Vernor Hwy., Detroit 48209
Kingswood, Roy C. (L)...........14310 Hamilton Ave., Highland Park 48203
Kitzmiller, John L...15901 W. 9 Mile Rd., Southfield 48075
Klaiber, Roger G........1541 Edsel Drive, Trenton 48183
Klein, Herman.......5030 Wallbrook, Birmingham 48010
Klein, Howard A.............1846 Dav. Whitney Bldg., Detroit 48226
Klein, Sander P...14825 W. McNichols Rd., Detroit 48235
Kleinman, Shmarya (L).....1800 Tuxedo, Detroit 48206
Klicka, Karl S.............33101 Annapolis, Wayne 48184
Kliger, David (L).........7756 Southfield, Detroit 48228
Klimchuk, M. M.....22770 Kelly Rd., East Detroit 48021
Klimkowski, Edw. J...........17301 W. Eight Mile Rd., Detroit 48235
Kling, George A..........Harper Hospital, Detroit 48201
Kling, Murray G.....22341 W. Eight Mile, Detroit 48219
Kluck, Clarence J.......25210 Grand River, Detroit 48240
Klutke, Geo. H. E.........2841 Monroe, Dearborn 48124
Knaggs, Earl J..........2387 Fort St., Wyandotte 48192
Knapp, Floyd B. (R)............202 Maple Grove Ave., Prudenville 48651
Knapp, Gary H............23611 Goddard, Taylor 48180
Knapp, Gordon R. (R)..........Virginia Madison Apts., Galax, Virginia 24333
Knapp, Wm. L...27740 Devonshire Dr., Southfield 48075
Knighton, Robt. S...2799 W. Grand Blvd., Detroit 48202
Knobloch, Edmund J. (L)..5933 Chene St., Detroit 48211
Knott, Stuart A...........100 Oak St., Wyandotte 48192
Knox, Ross M.........3180 Fort St., Lincoln Park 48146
Kobernick, Sidney D.....6767 W. Outer Dr., Detroit 48235
Kobiljak, Stefan H...3516 Fort Street, Lincoln Park 48146
Kochkodan, Eugene J.............2799 W. Grand Blvd., Detroit 48202
Koebel, Raymond H. (L)............409 N. Shore Dr., St. Clair Shores 48080
Koek, Hans J.........23100 Cherry Hill, Dearborn 48124
Koerber, Edward J....4876 Lakeview Ave., Detroit 48215
Kogan, Natalio............Sinai Hospital, Detroit 48235
Kogut, Constantine S.......10627 Puritan, Detroit 48238
Kokowicz, Raymond J.....19440 Van Dyke, Detroit 48234
Kolman, Isadore I...........1800 Tuxedo, Detroit 48206
Kondomerkos, John D...33020 Palmer Road, Wayne 48184
Kong, Leighton N. L.........Grace Hosp., Detroit 48201
Konno, Edward T.......1400 Chrysler Fwy., Detroit 48207
Kopf, George M. (A)............Detroit General Hosp., Detroit 48226
Kopmeyer, Joe M., Jr. 702 Parkman, Bloomfield Hills 48013
Koran, Valentine L.......1306 Kales Bldg., Detroit 48226
Koren, Louis......1300 Cadillac Sq. Bldg., Detroit 48226
Kornacki, Thomas E. (A) 3461 Cambridge, Detroit 48235
Korum, Lyle W.......18585 E. Warren St., Detroit 48236
Koschnitzke, H. K.....15101 Southfield, Allen Park 48101
Kossayda, Adam W...............15324 Michigan Ave., Dearborn 48126
Kovach, Emery P.........9750 Chalmers, Detroit 48213
Kovan, Dennis D.................16965 Hamilton Ave., Highland Park 48203
Kowaleski, John J.......12789 Veronica, Southgate 48192
Kozlinski, Anthony E...2195 E. Grand Blvd., Detroit 48211
Krabbenhoft, K. L.........3825 Brush St., Detroit 48201
Kraft, Raymond B. (R)............700 S. Ocean Blvd., Boca Raton, Fl. 33432
Kraft, Ruth M...19164 Devonshire Rd., Birmingham 48009
Krakauer, Bernard...........17716 W. Seven Mile Rd., Detroit 48235
Krass, Edward W.......11088 Gratiot Ave., Detroit 48213
Kraus, John J.......16840 E. Warren Ave., Detroit 48224
Krawec, Charles J............Mt. Carmel Mercy Hosp., Detroit 48235
Krebs, Wm. T.......16419 E. Warren Ave., Detroit 48224
Kreinbring, Geo. E....14295 E. 7 Mile Rd., Detroit 48205
Kretzschmar, John C...660 E. Grand Blvd., Detroit 48207
Krevsky, David A.......8449 Park Ave., Allen Park 48101
Krevsky, Harold.......8449 Park Ave., Allen Park 48101
Krevsky, Seymour..Detroit Memorial Hosp., Detroit 48226
Krieg, Earl G. (A)..757 Middlesex, Grosse Pte. Park 48236
Krieger, Harley L. (R)..11390 Strathmoor, Detroit 48227
Kristen, Karl T. (M)....................210 State St., New Orleans, La. 70118
Kritchman, Maurice J. (L).10 Witherell St., Detroit 48226
Kroha, Lawrence A...15124 Kercheval Ave., Detroit 48230
Krohn, Lawrence H...........24340 W. McNichols Rd., Detroit 48219
Kroll, H. Harvey V.......7815 E. Jefferson, Detroit 48214
Krull, Edward A.....482 Rivard Blvd., Grosse Pte. 48230
Krynicki, Francis X. (L)..15101 W. 7 Mile, Detroit 48235
Krystal, Henry..............19210 Coyle, Detroit 48235
Kubanek, Jos. L. (L).....23134 Myrtle, Dearborn 48128
Kucmierz, Francis S...18934 Van Dyke Ave., Detroit 48234
Kuehn, Ned N...20203 Wellesley Blvd., Birmingham 48010
Kuhn, Albert A.....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Henry H.....635 W. Seven Mile Rd., Detroit 48203
Kuhn, Richard F.......1700 Junction Ave., Detroit 48209
Kujawski, Walter F............17800 E. Eight Mile Rd., Detroit 48236
Kullman, Harold J. (A)..930 Beechmont, Dearborn 48124
Kuran, Lionel V........14853 Michigan, Dearborn 48126
Kurcz, Jos. A.........7433 Michigan Ave., Detroit 48210
Kurtz, Irvin J..........25210 Grand River, Detroit 48240
Kurtzman, Raymond S...........Detroit Memorial Hosp., Detroit 48226
Kutsche, John D............3794 Fort St., Trenton 48183
Kvietys, Benj.............27235 Joy Rd., Dearborn 48127
Kwasiborski, S. A........2300 Oak St., Wyandotte 48192
Kyle, Wm. V., Jr...........4741 Spokane, Detroit 48204
Laberge, James M............100 Oak, Wyandotte 48192
Lackey, Lawrence S............525 Visger, Ecorse 48229
LaCroix, George E...695 Vaughan, Bloomfield Hills 48013
Laderach, David C.........1704 Iroquois, Detroit 48214
Lafata, Philip J.........15260 Levan Rd., Livonia 48154
La Ferte, Alfred D. (L)..667 Neff Rd., Grosse Pte. 48230
Laham, M. M............2929 Fort St., Wyandotte 48192
Lahood, Michael J.......20001 Greenfield, Detroit 48235
Laige, Raymond J. (A).....P.O. Box 1259, Detroit 48231
Lajoie, Louis J.............601 Piquette, Detroit 48202
Lakatos, George C...........33020 Palmer, Wayne 48184
Lake, Robt. C...........8445 E. Jefferson, Detroit 48214
Lakin, Alan C...........17431 Greenfield, Detroit 48235
Lakin, Mervyn H...............18900 W. Ten Mile Rd., Southfield 48075
Lakoff, Chas. B. (L)............8233 W. Chicago Blvd., Detroit 48204
Lam, Conrad R.........Henry Ford Hosp., Detroit 48202
Lamberson, Frank A....19001 Grand River, Detroit 48223
Lammy, James V.............20867 Mack, Detroit 48236
Lamont, Richard L.....3815 Pelham Rd., Dearborn 48124
Lamontagne, Gaetan.....15830 Fort St., Southgate 48192
Lampman, Harold H. (L)........3011 W. Grand Blvd., Detroit 48202
Landers, Maurice B...275 W. Grand Blvd., Detroit 48216
Lang, Ernst F...........3790 Woodward, Detroit 48201
Lange, Wm. A.......3790 Woodward Ave., Detroit 48201
Langston, John D.....1420 St. Antoine St., Detroit 48226
Laning, Geo. M. (L)..R. D. Morey Rd., Sharon, Ct. 06069
Lansing, Eugene H......33020 Palmer Rd., Wayne 48184
Lansky, Mandell........16339 E. Warren, Detroit 48224
Large, Alfred M...701 Dav. Whitney Bldg., Detroit 48226
Largo, Donald J..........16717 Warwick, Detroit 48219
Larkin, Duane R.........28435 Plymouth, Livonia 48150
Larned, Richard I.........15208 Bringard, Detroit 48205
Larsen, Edward G......1803 Trenton Dr., Trenton 48183
Larsen, Robt. D........76 W. Adams Ave., Detroit 48226
Larson, Chas. J......12729 Cunningham, Southgate 48192
Larsson, Bror H. (L)....81 E. Kirby Ave., Detroit 48202
Lasichak, Andrew G....76 W. Adams Ave., Detroit 48226
Lasley, James W...1014 David Whitney Bl., Detroit 48226
Latimer, Fredk. R..........28 W. Adams, Detroit 48226
Latteier, Karl K.....15025 W. 8 Mile Rd., Detroit 48235
Lauppe, Edward H...1553 Woodward Ave., Detroit 48226
Lauppe, Fredk. A....1553 Woodward Ave., Detroit 48226
Laura, Albert L...........9105 Harrison, Livonia 48150
Laurisin, Eugene (L)........3019 W. 13 Mile, Apt. 413, Royal Oak 48073
Lauter, Eric W.............1800 Tuxedo, Detroit 48206
Lawand, Frank K.............952 David Whitney Bldg., Detroit 48226
Lawrence, Louis F...............15901 W. 9 Mile Rd., Southfield 48075
Lazar, Morton R.......20905 Greenfield, Southfield 48075
Leach, David............430 Fisher Bldg., Detroit 48202
Leach, Robt. B...........1401 Rivard St., Detroit 48207

Leach, Wendell L.......10811 E. Warren, Detroit 48214
Leacock, Robt. C.....440 University Pl., Grosse Pte. 48236
Leader, Luther R. (L)...........3535 W. 13 Mile Rd., Royal Oak 48072
Leaver, L. Ross.......757 Lakewood Ave., Detroit 48215
Lebamoff, Alexander T...7940 Allen Rd., Allen Park 48101
Lechner, Monroe S...22770 Kelly Rd., East Detroit 48021
Lecklider, A. F. (R)..848 Berkshire Rd., Grosse Pte. 48230
Lee, Frank........501 Meadowlane Dr., Dearborn 48124
Lee, Harry E. (L)....13616 Gratiot Ave., Detroit 48205
Lee, Pyong Tai....15901 W. 9 Mile Rd., Southfield 48075
Leeser, Robert L...23100 Cherry Hill Rd., Dearborn 48124
Lehmann, Robert N...........26029 West Five Mile Rd., Detroit 48229
Leipsitz, Louis S..........3566 Cass Ave., Detroit 48201
Leiter, Forrest C..........2355 Monroe, Dearborn 48124
Leithauser, Daniel J. (L)..........80 Lakeshore Lane, Grosse Pointe Shores 48236
Leland, Louis S...867 Grosse Pte. Court, Grosse Pte. 48230
Leland, Solomon........6563 Grand River, Detroit 48208
Lemley, Clark F. (L) 3011 W. Grand Blvd., Detroit 48202
Lemon, Bruce K.......20905 Greenfield, Southfield 48075
Lentine, James J........15831 Mack Ave., Detroit 48224
Lenz, Willard R...........418 Moran Rd., Detroit 48236
Lepard, Cecil W.....1553 Woodward Ave., Detroit 48226
Lepley, Fred O. (L)................19799 Mack Ave., Grosse Pte. Woods, 48236
Lepley, Frederick J.......19803 Mack, Grosse Pte. 48236
Lerman, Saml. I...........18330 Parkside, Detroit 48221
Lerner, A. Martin.....1400 Chrysler Exp., Detroit 48207
Lerner, Leonard H.............7310 W. Seven Mile Rd., Detroit 48221
LeRoy, George V............1800 Tuxedo, Detroit 48206
Lesesne, John M...17700 Mack Ave., Grosse Pointe 48236
Leslie, C. G.............8401 Woodward, Detroit 48202
L'Esperance, Simon P. L. (R)...........18707 Freeland Detroit 48235
Lessani, Nasi D......36180 Five Mile Rd., Livonia 48154
Lessem, David...12759 Vernon, Huntington Woods 48070
Lester, Melvin A.................26831 Woodward Ave., Huntington Wds. 48070
Leszynski, Jos. S. (L)....8120 E. Jefferson, Detroit 48214
Leucutia, Traian (L)........10 Peterboro, Detroit 48201
Levagood, Floyd B.......3790 Woodward, Detroit 48201
Levant, Arthur B........15715 E. Warren, Detroit 48224
Levenson, Malcolm L......24500 Custis, Southfield 48075
Leventer, Ira....20211 Ann Arbor Trail, Dearborn 48127
Levick, Walter G....19959 Vernier, Harper Woods 48236
Levin, David M. (A)................3505 E. Campbell, Phoenix, Az. 85018
Levin, Herbert G..........17300 Schaefer, Detroit 48235
Levin, M. Mitchel.....20905 Greenfield, Southfield 48075
Levin, Saml. J.......3011 W. Grand Blvd., Detroit 48202
Levine, Edward E...................12891 Sherwood, Huntington Woods 48070
Levitt, Irving........24535 N. Carolina, Southfield 48075
Levitt, Nathan (L).......607 Kales Bldg., Detroit 48226
Levy, David B.............29586 Fenkell, Livonia 48151
Levy, Marvin B...23200 Woodward Ave., Ferndale 48220
Levy, Stanley H.....10601 Seven Mile Rd., Detroit 48221
Lewin, Harry (L)...27012 Knob Woods, Southfield 48075
Lewis, Benjamin M..........1401 Rivard, Detroit 48207
Lewis, Harvey Y...14219 W. McNichols Rd., Detroit 48235
Lewis, J. Hugh (L)....1543 Ford Ave., Wyandotte 48192
Lewis, Lee A.......2730 E. Jefferson Ave., Detroit 48207
Lewis, Robt. H....17401 Roseland, Lathrup Village 48075
Lewis, Wilfrid J..........10 Peterboro St., Detroit 48201
Libbrecht, Robt. V.....6540 Park Ave., Allen Park 48101
Lichter, Max L...2900 Oakwood Blvd., Melvindale 48127
Lichty, Dorman E.......7701 Wyoming, Dearborn 48126
Liddicoat, Arthur G. (L)....20125 Fenkell, Detroit 48223
Lie, Kim K.............1408 Kales Bldg., Detroit 48226
Lieberman, Barnard L............19212 Woodward Ave., Detroit 48203
Lightbody, James J. (L)..7815 E. Jefferson, Detroit 48214
Lightbourn, George A.....18984 Livernois, Detroit 48221
Lignell, Rudolph W...........401 Northland Med. Bldg., Southfield 48075
Liioi, Joseph A.....17000 W. 8 Mile Rd., Southfield 48075
Lilly, Robert P.......15240 Merriman Rd., Livonia 48154
Lindner, David W....3800 Woodward 822, Detroit 48201
Linkner, Leonard S..............12944 La Salle Lane, Huntington Woods 48070
Lipinski, Stanley L.....7540 Michigan Ave., Detroit 48210
Lipkin, Ezra (L).....5715 Michigan Ave., Detroit 48210
Lipnik, Carl E.......31610 Plymouth Rd., Livonia 48150
Lipnik, Morris J...17000 W. Eight Mile, Southfield 48075
Lipschutz, Louis S...19750 Chesterfield Rd., Detroit 48221
Lipson, Channing T...20101 James Couzens, Detroit 48235
Lipson, Madeleine L.........1800 Tuxedo, Detroit 48206
Lipton, Raymond F.......10 Peterboro St., Detroit 48201
Litsky, Abraham D.....1183 E. Grand Blvd., Detroit 48211
Little, James W. 3637 Franklin Rd., Bloomfield Hills 48013
Litwin, Jack A....15121 W. McNichols Rd., Detroit 48235
Litzenberger, D. J......2429 Oakwood, Melvindale 48127
Livingood, Clarence S...345 University, Grosse Pte. 48236
Livingston, W. C.............10720 W. Seven Mile Rd., Detroit 48221
Lloyd, James R...1515 Dav. Whitney Bldg., Detroit 48226
Lo, Lien Fu................1800 Tuxedo, Detroit 48206
Lo, Molly Tan.............Sinai Hospital, Detroit 48235
Lockhart, Edward C........7569 Tireman, Detroit 48204
Lockwood, Bruce C. (L)....180 Isle of Venice Apt. 122, Ft. Lauderdale, Fla. 33301
Lofstrom, James E...............3601 W. 13 Mile Rd., Royal Oak 48072
Logrippo, Annie B.....Henry Ford Hosp., Detroit 48202
Lohmann, Carl W.............1229 Dav. Whitney Bldg., Detroit 48226
London, Berton L..........18510 Meyers, Detroit 48235
Londono, Javier H. (A)....Tuft New Eng. Med. Hosp., Boston, Ma. 02111
Long, Earl C. (L)..........19751 James Couzens Hwy., Detroit 48235
Long, John J.......15901 Greenfield Ave., Detroit 48227
Longo, Salvatore............468 Cadieux, Detroit 48230
Loomis, John L.......236 Visger Rd., River Rouge 48218
Loomus, Gerald N.....4100 W. McNichols, Detroit 48221
Lopatin, Reuben....22161 W. Outer Dr., Dearborn 48124
Lopez, Rodolfo (A)........Grace Hospital, Detroit 48201
Loranger, C. B. P............20825 Mack, Detroit 48236
Lorber, Jos. H.........873 Lakewood Ave., Detroit 48215
Lorentzen, Edwin H. (L).......11702 Grand River Ave., Detroit 48204
Lovas, Wm. S.........3577 Fort St., Lincoln Park 48146
Love, Donald M..............32665 Utica, Fraser 48026
Love, James M..........16565 Bentler St., Detroit 48219
Lowe, Adolph W...3338 W. Davison Ave., Detroit 48238
Lowinger, Paul L.........951 E. Lafayette, Detroit 48207
Lowrie, Wm. L. (L)..2799 W. Grand Blvd., Detroit 48202
Luby, Elliot D.........19680 Roslyn Rd., Detroit 48221
Lucas, Robert J..........771 Fisher Bldg., Detroit 48202
Lui, Alfred H. F...Wayne Co. Gen. Hospital, Eloise 48132
Lumpkin, John G., Jr...243 E. Warren Ave., Detroit 48201
Lutz, Earl F. (R).................2920 N. E. 55th St., Ft. Lauderdale, Fl. 33308
Lutz, Sherwin J......15121 W. McNichols, Detroit 48235
Luz, Denis A.....Bon Secours Hospital, Grosse Pte. 48236
Luzadre, John H.........18430 Mack Ave., Detroit 48236
Lynn, David H.......Lynn Hospital, Lincoln Park 48146
Lynn, Harvey D.......3815 Pelham Rd., Dearborn 48124
Lytle, Robt. P...............402 Northland Med. Bldg., Southfield 48075
Maben, Hayward C., Jr...554 Fisher Bldg., Detroit 48202
Mabley, John D. (L)..1037 David Whitney, Detroit 48226
MacDougall, Orrin P.............13700 Woodward Ave., Detroit 48203
MacFarlane, Howard W. (L)......1553 Woodward Ave., Detroit 48226
MacGregor, Wm. W. (L)......1111 N. Woodward Ave., Birmingham 48011
Mack, Harold C......3011 W. Grand Blvd., Detroit 48202
Mack, Robert E.........Womans Hospital, Detroit 48201
Mac Kenzie, Earle D. (L)..81 E. Kirby St., Detroit 48202
Mackersie, Wm. G. (L)...........18205 Roselawn Ave., Detroit 48221
Mac Leod, Chas. W...16345 W. McNichols, Detroit 48235
MacMillan, Francis B.............1553 Woodward Ave., Detroit 48226
MacNeil, John J. 2075 E. 14 Mile Rd., Birmingham 48008

Mac Pherson, K. C. (L)..8100 E. Jefferson, Detroit 48214
Mac Queen, Malcolm D. (L).......660 Woodward Ave., Detroit 48226
Maczewski, John E.......22790 Kelly, East Detroit 48021
Mader, Ivan J.....3535 W. 13 Mile Rd., Royal Oak 48072
Madrid, Ramon A..10151 Michigan Ave., Dearborn 48126
Magnell, Ralph C.............20100 W. McNichols Rd., Detroit 48219
Maguire, Clarence E.............1553 Woodward Ave., Detroit 48226
Mahanti, Biresh C.......2300 Oak St., Wyandotte 48192
Mahlin, Murray S....16820 Greenfield Ave., Detroit 48235
Mahoney, Hugh M...1553 Woodward Ave., Detroit 48226
Maibauer, Fredk. P...2934 Biddle Ave., Wyandotte 48192
Mainwaring, Rosser L...24601 Fairmount, Dearborn 48124
Maire, Edward D.......15224 E. Jefferson, Detroit 48230
Maisel, Harry............19980 Renfrew, Detroit 48221
Maitland, Ruth J.....Mich. Bell Telephone, Detroit 48226
Majauskas, V. E...........23738 Joy Rd., Detroit 48239
Majzoub, Ahmad J........3334 Fort, Lincoln Park 48146
Malina, Stephen (A)........2820 Woodslee Dr., #401, Royal Oak 48073
Malje, Frank J.....Garden City Clinic, Garden City 48135
Malone, John M.......17300 Schaefer Rd., Detroit 48235
Malone, Robert E.....15101 Southfield, Allen Park 48101
Maloney, John A. (L)............670 Maccabees Bldg., Detroit 48202
Maloney, Philip J......16401 Grand River, Detroit 48227
Maltzer, Jos. H.....26505 John R., Madison Hghts. 48071
Mammel, Bernard T...........14447 W. Seven Mile Rd., Detroit 48235
Mancuso, Vincent S. (L)..........611 S. W. 38th Ave., Ft. Lauderdale, Fl. 33312
Mandel, Leslie........26750 Grand River, Detroit 48240
Mandelbaum, B............432 E. Hancock, Detroit 48201
Mandell, Gerald H.........Sinai Hospital, Detroit 48235
Mandiberg, Jack N............22341 W. Eight Mile Rd., Detroit 48219
Mankani, Hari B.......2000 Second Ave., Detroit 48226
Mann, Andrew D...........20901 Moross, Detroit 48236
Manning, Morey H...950 E. State Fair Ave., Detroit 48203
Manson, Gordon........Henry Ford Hosp., Detroit 48202
Manzor, Alberto.307 David Whitney Bldg., Detroit 48226
Mapletoft, Kenneth E.....420 Mohawk, Dearborn 48124
Marcotty, Andreas................28035 Southfield Rd., Lathrup Village 48075
Marcus, Edwin L.....15101 Southfield, Allen Park 48101
Marecki, Vincent J...10326 W. Warren, Dearborn 48126
Margherio, Raymond R. (A).......Ophthalmology Dept., Detroit General Hosp., Detroit 48226
Margolis, Marvin O........18205 Parkside, Detroit 48221
Margules, Saul Z.....11846 E. McNichols, Detroit 48205
Marinus, Carleton J. (L).........1553 Woodward Ave., Detroit 48226
Mark, Jerome....513 David Whitney Bldg., Detroit 48226
Markey, Alexander P..............14853 Michigan Ave., Dearborn 48126
Markey, Frank R..........17174 Fairfield, Detroit 48221
Markoe, Rupert C. L. (L)..7600 John R St., Detroit 48202
Marks, Ben.....232 W. Grand River Ave., Detroit 48226
Marks, Bert W.......................8250 Lincoln Dr., Huntington Woods 48070
Marsh, Alton R. (L)..............15696 Woodland Dr., Dearborn 48120
Marshall, James R. (L).........14827 E. Jefferson Ave., Detroit 48215
Marshall, J. R., Jr.......20160 Mack Ave., Detroit 48236
Martin, J. B., Jr........449 E. Elizabeth St., Detroit 48201
Martin, Lyndle R......2000 Second Blvd., Detroit 48226
Martin, Peter A.........857 Fisher Bldg., Detroit 48202
Martin, Walter..........13800 Livernois, Detroit 48238
Martin, Wilbur C.......10401 W. Chicago, Detroit 48204
Martinez, Alvaro (M)......................1004 S. 13th, Copperas Cove, Tx. 76522
Martinez, Pedro O. (L)..1439 Bagley Ave., Detroit 48216
Martmer, Edgar E................693 Washington Rd., Grosse Pte. 48236
Marwil, Thos. B...21751 W. 11 Mile Rd., Southfield 48075
Marvin, Robert C.........22362 Morley, Dearborn 48124
Mascarin, T. A...........18101 E. Warren, Detroit 48224
Mathis, Perry L...........3239 Clements, Detroit 48238
Matthews, Burton V...13724 W. Fort St., Southgate 48192
Mattman, Paul E..........1500 Seminole, Detroit 48214
Mattson, Theo. M.....901 W. Grand Blvd., Detroit 48208
Mauch, Eugene W....15101 Southfield, Allen Park 48101
Mauthe, Harry G.......16859 Pollyana Dr., Livonia 48154
Maynard, Fredk. M.....6828 Park Ave., Allen Park 48101
Mays, William O.........19737 Cheyenne, Detroit 48235
Maywood, F. N. 20840 Vernier Rd., Harper Woods 48236
McAlonan, William T. (L) 10 Peterboro St., Detroit 48201
McAlpine, Gordon S. (L)................875 Henrietta, Birmingham 48009
McBryan, Thos. J....21420 Harper, St. Clair Shores 48080
McCadie, James H...............13700 Woodward Ave., Highland Park 48203
McCall, Marion G., Jr.............2930 W. Grand Blvd., Detroit 48202
McCandless, Virginia....270 S. Melborn, Dearborn 48124
McCaughey, R. S.....Wayne St. University, Detroit 48207
McClellan, Robt. J....16345 W. McNichols, Detroit 48235
McClelland, Rachael L.............33026 Five Mile Rd., Livonia 48154
McClendon, James J. (L)..8401 Woodward, Detroit 48202
McClure, Robt. W........9111 E. Outer Dr., Detroit 48213
McClure, Wm. R. (L).....................Box 1498, Boynton Beach, Fl. 33435
McCole, C. E..........Henry Ford Hosp., Detroit 48202
McColl, Chas. W....2025 Ford Avenue, Wyandotte 48192
McColl, Clarke M. (L)...........2799 W. Grand Blvd., Detroit 48202
McCollum, E. Bert..........20867 Mack, Detroit 48236
McCord, Carey P. (L)...........Sch. of Public Health, Ann Arbor 48104
McCormick, Colin C. (A).........24352 Rockford Ave., Dearborn 48124
McCue, Francis B......7106 Park Ave., Allen Park 48101
McCullough, L. E.............1711 Dav. Whitney Bldg., Detroit 48226
McCutcheon, Sue A....Henry Ford Hosp., Detroit 48202
McDonald, Angus L. (L)....15125 Gratiot, Detroit 48205
McDonald, John R..........Harper Hosp., Detroit 48201
McDonald, Wm. G. 15600 Michigan Ave., Dearborn 48126
McEvitt, Wm. G.....1140 W. Boston Blvd., Detroit 48202
McGee, T. Manford.....22000 Greenfield, Oak Park 48237
McGinnis, Kenneth D...6071 W. Outer Dr., Detroit 48235
McGlaughlin, N. D...2312 Biddle Ave., Wyandotte 48192
McGough, Jos. M......18716 Grand River, Detroit 48223
McGuire, John F..........3815 Pelham, Dearborn 48124
McHenry, John T.........1401 Rivard St., Detroit 48207
McIntosh, C. W.......8355 Gratiot Ave., Detroit 48213
McIntosh, Robt. D.......6307 W. Fort St., Detroit 48209
McIntyre, Wm. B.............1145 Dav. Whitney Bldg., Detroit 48226
McKean, G. Thos....1553 Woodward Ave., Detroit 48226
McKeever, Geo. E...5237 Oakman Blvd., Dearborn 48126
McKenna, Chas. J........14618 E. 7 Mile, Detroit 48205
McKnight, Robt. E................15901 W. 9 Mile Rd., Southfield 48075
McLane, Harriet I. E. (L).1367 Nicolet Pl., Detroit 48207
McLaughlin, James T............Wyandotte Gen. Hosp., Wyandotte 48192
McLaurin, Jasper E.........5050 Joy Rd., Detroit 48204
McLean, Brita R...............1365 Cass, Detroit 48226
McLean, Don W........1066 Fisher Bldg., Detroit 48202
McLean, Donald C.......459 Fisher Bldg., Detroit 48202
McManamon, Thomas V. Ford Motor Co., Dearborn 48127
McNamara, Joseph M.....9430 S. Main, Plymouth 48170
McNeill, Roger F........63 Kercheval, Grosse Pte. 48236
McNichol, L. J...18424 W. McNichols Rd., Detroit 48219
McPhee, Roderick T.....................21503 Harper, St. Clair Shores 48080
McQuiggan, Mark R..........700 Seward, Detroit 48202
Meara, Joseph F......Detroit Mem. Hosp., Detroit 48226
Mediodia, Gil H.......22101 Moross Rd., Detroit 48236
Meek, Stuart F.........29542 Hoover Rd., Warren 48093
Melander, L. W., Jr..........1229 David Whitney Bldg., Detroit 48226
Mellen, Hyman S........16800 Greenfield, Detroit 48235
Mellinger, Raymond C...959 Pemberton, Grosse Pte. 48236
Melnik, Maxim P.....3011 W. Grand Blvd., Detroit 48202
Melnyczuk, Nestor......19600 W. Warren, Detroit 48228

Menczer, Richard....................29081 Dequindre, Madison Heights 48071
Mendelson, Herbert....15200 Northfield, Oak Park 48237
Mendelssohn, A. N.....8100 E. Jefferson, Detroit 48214
Mendelssohn, Reuben J..........8100 E. Jefferson Ave., Detroit 48214
Mendians, Edgar V......9486 Beaconsfield, Detroit 48224
Mendoza, Saml............6356 Michigan, Detroit 48210
Menton, Norman J....15300 W. McNichols, Detroit 48235
Mercader, Rodolfo S.....35337 W. Warren, Wayne 48184
Merkel, Chas. C.....................85 Kercheval Ave., Grosse Pte. Farms 48236
Merkle, Karl..........530 N. Telegraph, Dearborn 48128
Merrill, C. R., Jr..........1951 Monroe, Dearborn 48124
Merritt, Earl G...........3790 Woodward, Detroit 48201
Mersky, Charlotte I. (A)............32215 Queensboro, Farmington 48024
Metes, John S.....62 Webber Pl., Grosse Pte. Shores 48236
Metzger, Harry C.....................25504 Wareham, Huntington Woods 48070
Meyer, Eugene.........15830 Fort St., Southgate 48192
Meyer, John S.........Wayne State Univ., Detroit 48207
Meyer, Kenneth R.......Oakwood Hosp., Dearborn 48124
Meyers, Marjorie P.......3790 Woodward, Detroit 48201
Meyers, Maurice P.....6767 W. Outer Dr., Detroit 48235
Michael, Cleon M.......32300 Schoolcraft, Livonia 48150
Michael, Michael J..........15901 W. 9 Mile Rd., #400, Southfield 48075
Migdoll, David.......15361 Plymouth Rd., Detroit 48227
Mihay, Benjamin..........2021 Monroe, Dearborn 48124
Mikesell, W. B., Jr.........23611 Goddard, Taylor 48180
Mikhail, George.......Henry Ford Hosp., Detroit 48202
Milauskas, A. T.......100 Oak Street, Wyandotte 48192
Mileris, Vytautas....2730 E. Jefferson Ave., Detroit 48207
Millard, Glenn E.........958 Fisher Bldg., Detroit 48202
Miller, Antonina.......16989 Farmington, Livonia 48154
Miller, Danl. H.......23100 Cherry Hill, Dearborn 48124
Miller, Elmer B...7 John Glenn Place, Highland Park 48203
Miller, George W...................26401 Harper Ave., St. Clair Shores 48080
Miller, Jacob J.......20131 James Couzens, Detroit 48235
Miller, J. Martin....2799 W. Grand Blvd., Detroit 48202
Miller, Jose W...........Childrens Hosp.., Detroit 48202
Miller, Karl L.......1553 Woodward Ave., Detroit 48226
Miller, Myron H. (L).............27330 Southfield Rd., Lathrup Village 48075
Miller, Oscar W............Fleetwood Plt. Fbd., G.M.C., Detroit 48209
Miller, Thos. H...1305 Dav. Whitney Bldg., Detroit 48226
Miller, Wm. E. (L).........10 Peterboro, Detroit 48201
Miller, William J.....5649 Inkster Rd., Garden City 48135
Mills, Clinton C...16190 Jas. Couzens Hwy., Detroit 48221
Mills, Geo. R........8209 Allen Road, Allen Park 48101
Milton, Samuel B.................26560 W. Outer Dr., Lincoln Park 48146
Min, Byong G....................23312 Masonic Blvd., St. Clair Shores 48082
Mines, Robert E., Jr. (M)........8401 Woodward Ave., Detroit 48202
Mintz, Edward I.........954 Fisher Bldg., Detroit 48202
Mintz, Morris J..........17563 Greenfield, Detroit 48235
Minui, Morteza..1576 Kirkway Dr., Bloomfield Hills 48013
Mishelevich, Sophie (L).........4651 E. Nine Mile Rd., Warren 48091
Miskinis, Martyna.....393 W. Grand Blvd., Detroit 48216
Missavage, Edward, Jr...........Wayne Co. Genl. Hosp., Eloise 48132
Mitchell, A. W..............12000 Visger, Detroit 48217
Mitchell, C. Leslie......Henry Ford Hosp., Detroit 48202
Mitchell, Darnell P...8401 Woodward Ave., Detroit 48202
Mitchell, Oscar C.......2033 E. Davison, Detroit 48212
Mitchell, Roy A.......1992 Ardmore Rd., Trenton 48183
Mitri, Moufid.............VA Hospital, Dearborn 48121
Moehlig, Robt. C. (L)...........3001 W. Grand Blvd., Detroit 48202
Moghissi, Kamran S...............502 Professional Plaza, 3800 Woodward Ave., Detroit 48201
Mogill, Geo...........3150 Second Blvd., Detroit 48201
Moisides, Vasil P. (L)..28 W. Adams Ave., Detroit 48226
Molitz, Howard (A)..............Ophthalmology Dept., Detroit General Hosp., Detroit 48226
Moll, Clarence D. (L)....10 Peterboro St., Detroit 48201
Molner, Jos. G.....14890 Glastonbury Rd., Detroit 48223
Momcilovich, Boxidar............2241 Huron River Dr., Rockwood 48173
Mond, Edward...........10 Witherell St., Detroit 48226
Monge-St. Laurent, E............23607 Farmington Rd., Farmington 48024
Monson, Robt. C...........17520 Chester, Detroit 48224
Montante, Jos R...................3040 Middlebelt Rd., Orchard Lake 48033
Montenegro, Milton.......18512 Hillcrest, Livonia 48152
Montgomery, Wm. C.................26711 Woodward, Huntington Woods 48070
Monto, Raymond W.....Henry Ford Hosp., Detroit 48202
Moore, John W., Jr....8251 W. 8 Mile Rd., Detroit 48221
Moore, Warren R.....17800 E. 8 Mile Rd., Detroit 48236
Moore, Wesley P............Wayne County Gen. Hosp., Eloise 48132
Mopper, Coleman..14633 E. Seven Mile Rd., Detroit 48205
Morales, Miriam V.................402 Deerfield Lane, St. Matthews, Ky. 40207
Moran, Frank J.........16311 Middlebelt, Livonia 48154
Morand, Louis J. (A)......18944 Fairfield, Detroit 48221
Morgan, Donald N...............17800 E. 8 Mile Rd., Harper Woods 48236
Morgan, Philip J...1575 Cherboneau, A 53, Detroit 48207
Moriarty, Geo. J.....3011 W. Grand Blvd., Detroit 48202
Morita, Yoshikazu 3535 W. 13 Mile Rd., Royal Oak 48072
Morley, Arthur R.....15753 Promenade, Allen Park 48101
Morley, George M.....12922 W. Warren, Dearborn 48126
Morley, Harold V.........970 Fisher Bldg., Detroit 48202
Morley, James A. (L)............10514 Plymouth Ave., Detroit 48204
Morley, Thomas S.........4160 John R St., Detroit 48201
Moroun, Sheffick J............675 Parker, Detroit 48214
Morris, Harold L. (L)..........26111 Meadowbrook Rd., Novi 48050
Morrison, George W...........2033 Park, Detroit 48226
Morse, William H......19203 Grand River, Detroit 48223
Morton, David G.........19445 Plymouth, Detroit 48228
Moseley, Fredk. L........2561 S. Schaefer, Detroit 48217
Mosen, Max M. (A)..................26116 York Rd., Huntington Woods 48070
Moser, Peter F...............26082 E. Huron River Dr., Flat Rock 48134
Moses, John W...Mt. Carmel Mercy Hosp., Detroit 48235
Moss, Ervin B. (A).......23295 Kipling, Oak Park 48237
Moss, Nathan H...........2847 Trumbull, Detroit 48216
Moss, Norman D...............25919 Meadowlane Dr., Southfield 48075
Moss, Selma S........20905 Greenfield, Southfield 48075
Mott, Carlin P. (L)..2395 W. Grand Blvd., Detroit 48208
Moynihan, John W...2841 Monroe Blvd., Dearborn 48124
Mozen, Herschel E.....300 W. McNichols, Detroit 48203
Mucasey, John......22341 W. 8 Mile Rd., Detroit 48219
Mulero, Hector L.................15101 Southfield Rd., Allen Park 48101
Mullen, Jos. R........19003 Ecorse Rd., Allen Park 48101
Munecas, Rene A...........1554 Tuxedo, Detroit 48206
Munson, Henry T........7815 E. Jefferson, Detroit 48214
Murphy, Scipio G....8401 Woodward Ave., Detroit 48202
Murray, Gordon M.........9901 Whittier, Detroit 48224
Murray, Ian H. L.........474 Fisher Bldg., Detroit 48202
Murray, Robt. J..........3700 West Rd., Trenton 48183
Murray, Thomas H.....25239 Southfield, Southfield 48075
Muske, Paul H........13244 W. Warren, Dearborn 48126
Mutlu, Kadri K......35337 West Warren, Westland 48184
Myers, Danl. W.........1150 Bedford Rd., Detroit 48230
Myers, Steven A.........951 E. Lafayette, Detroit 48207
Nahigian, Russell...17371 Annchester Ave., Detroit 48219
Nahoum, Antoine........1030 Kensington, Detroit 48230
Nash, Edward B.........4075 Inkster Rd., Inkster 48141
Naud, Joseph H...412 Dav. Whitney Bldg., Detroit 48226
Navalta, Dominador G..14868 Reeck St., Southgate 48192
Navori, Cornelius A...3516 Fort Street, Lincoln Park 48146
Naylor, Arthur (L)............2100 N. Tipsico Lk. Rd., Milford 48042
Neeb, Walter G.......16840 E. Warren St., Detroit 48224

Nehra, John M............17800 E. 8 Mile Rd., #412, Grosse Pointe 48236
Neill, Edwin J..............5026 Bedford, Detroit 48224
Nelson, Darwin M...........63 Ridge Rd., Detroit 48236
Nelson, Harry M. (L) 3001 W. Grand Blvd., Detroit 48202
Nelson, Norman A.........Wayne County Genl. Hosp., Eloise 48132
Nelson, Victor E.......3025 Crooks Rd., Royal Oak 48073
Nesbit, Warren S..........24382 Ross Ct., Detroit 48239
Neufeld, Paul N.............17000 W. Eight Mile Rd., Southfield 48075
Newman, Ernest (R)..17371 Evergreen St., Detroit 48219
Newman, Geo. F.....2012 Monroe Blvd., Dearborn 48124
Newman, Max K....16861 Wyoming Ave., Detroit 48221
Newton, Kenneth......11841 Susan Ave., Warren 48093
Newton, Nicholas (A)......15252 Gratiot, Detroit 48205
Nichols, Wallace, Jr.........2387 Ashby, Trenton 48183
Nickel, Warren O..........861 Monroe, Dearborn 48124
Nickels, Albert W..3535 W. 13 Mile Rd., Royal Oak 48072
Nielsen, Aage E.........3790 Woodward, Detroit 48201
Nielsen, Donald R...............26339 Woodward Ave., Huntington Woods 48070
Nigro, Norman D.......7815 E. Jefferson, Detroit 48214
Nill, John B. (L)........15001 E. Warren, Detroit 48224
Nill, Wm. F. (L)........15001 E. Warren, Detroit 48224
Nino, Luis A...25638 Chapelweigh Dr., Farmington 48024
Noble, Wm. C..........4045 W. Jefferson, Ecorse 48229
Nolan, Bernard E.....5460 Schaefer Rd., Dearborn 48126
Nolting, Wilfred S. H............15850 E. Warren Ave., Detroit 48224
Northcross, David C...2929 W. Boston Blvd., Detroit 48206
Norton, Arthur B. (L)..1077 Fisher Bldg., Detroit 48202
Norton, Martin L....1400 Chrysler Expwy., Detroit 48207
Noshay, Wm. C......2799 W. Grand Blvd., Detroit 48202
Novy, Robt. L. (L)......858 Fisher Bldg., Detroit 48202
Nowicki, Kenneth M......Harper Hospital, Detroit 48201
Nowosielski, P. F...1305 Berkshire, Grosse Pte. Park, 48230
Nwokedi, C.............12000 Visger Rd., Detroit 48217
Nyboer, Jan.............Harper Hospital, Detroit 48201
Nyboer, Victor J........261 Mack Blvd., Detroit 48201
O'Brien, Geo. M...18239 W. Seven Mile Rd., Detroit 48219
O'Bushkevich, Leon S...15720 W. Warren, Detroit 48228
O'Connor, Katheryn L....17711 Schoolcraft, Detroit 48227
O'Donnell, Dayton H.....22000 Greenfield, Detroit 48237
O'Donnell, Eugene P...2615 W. Jefferson, Trenton 48183
O'Donnell, Kevin T.....15901 W. Nine Mile Rd., #514, Southfield 48075
Oetting, Edward M.....1041 Whittier, Grosse Pte., 48236
O'Gawa, Gilbert M...Henry Ford Hospital, Detroit 48202
Ohmart, Galen B. (L)...........8721 E. Jefferson Ave., Detroit 48214
Ohorodnik, Julius M...Bon Secours Hospital, Detroit 48230
Okun, Milton H.....3261 Sherbourne Rd., Detroit 48221
Oldford, Joseph R...17000 W. 8 Mile Rd., Southfield 48075
Olejniczak, Stanley..........Wayne County Gen Hosp., Eloise 48132
Olen, Alex............13100 Harper Ave., Detroit 48213
O'Linn, Francis P.........1055 Fisher Bldg., Detroit 48202
Olmsted, Geo. S...27305 Southfield, Lathrup Village 48075
Olson, Avis M.....Mt. Carmel Mercy Hosp., Detroit 48235
Olson, Donald T...17701 W. McNichols Rd., Detroit 48235
Olson, George P...........Chrysler Corp., Detroit 48235
Olson, James A...17000 West 8 Mile Rd., Southfield 48075
Olsztyn, Stanley R.........18326 Muirland, Detroit 48221
Oppenheim, Jos. M.........24091 Dante, Oak Park 48237
Ormond, Robt. S.....2799 W. Grand Blvd., Detroit 48202
O'Rourke, Paul V. (A)....2635 Woodstock, Detroit 48203
O'Rourke, Randall M.........7384 12th St., Detroit 48206
Ortiz, Armando............15901 W. 9 Mile Rd., #200, Southfield 48075
Ortiz, Eduardo (A)..Henry Ford Hospital, Detroit 48202
Osius, Eugene A. (L)..........901 Dav. Whitney Bldg., Detroit 48226
Ostrowski, Arthur Z...........610 Northland Med. Bldg., Southfield 48075
Otlewski, Eugene A...............15901 W. 9 Mile Rd., Southfield 48075
Ottaway, John P......................18226 Mack Ave., Grosse Pte. Farms 48236
Otto, Donald.....Det. Memorial Hospital, Detroit 48226
Owen, Clarence I. (L).................2689 Dupont, Jacksonville, Fl. 32217
Oz, Mustafa C...Wayne County Genl. Hosp., Eloise 48132
Palmer, Alice E...810 Dav. Whitney Bldg., Detroit 48226
Palmer, Milton R.......8700 Dexter Blvd., Detroit 48206
Palmer, Peter..........15830 Fort St., Southgate 48192
Palmisano, I. J........25447 Plymouth Rd., Detroit 48239
Panczak, Tamara..Plymouth State Hosp., Northville 48167
Panic, Stephen M.....1001 W. Seven Mile, Detroit 48203
Pantos, Theo. G...1536 Dav. Whitney Bldg., Detroit 48226
Parfanowycz, S. N. (A)....3347 Grant St., Detroit 48212
Parker, Benj. R...19149 W. Seven Mile Rd., Detroit 48219
Parnell, John W....................21 Whitcomb Dr., Grosse Pte. Farms 48236
Parr, Robt. W. (A)..1126 Audubon Rd., Grosse Pte. 48230
Parrish, Rufus H. (A).....2610 Sturtevant, Detroit 48206
Pasternacki, N. T..........6203 Chene St., Detroit 48211
Pastorius, Melvin K.......22835 Wilson, Dearborn 48128
Patton, Roy B..........Henry Ford Hosp., Detroit 48202
Paul, Lloyd J............19321 Greenfield, Detroit 48235
Pawlowski, Jerome I. (L)..........2009 E. Grand Blvd., Detroit 48211
Payne, Eugene H. (R)...............General Delivery, Bonita Springs, Fl. 33923
Payne, Walter A., Jr.....283 Hillcrest, Grosse Pointe 48236
Paysner, Harry A...............13700 Woodward Ave., Highland Park 48203
Pearce, Arthur J......26491 Carol, Franklin Village 48025
Pearlman, Jack..25860 Concord, Huntington Woods 48070
Pearse, Harry A. (L)............17000 W. Eight Mile, Southfield 48075
Pedersen, Herbert E....3815 Pelham Rd., Dearborn 48124
Peggs, Geo. F.........5419 Livernois Ave., Detroit 48210
Peisojovich, M. (A)........Grace Hospital, Detroit 48201
Pendy, Geo. V...1001 Dav. Whitney Bldg., Detroit 48226
Pendy, John M....1001 David Whitney Bl., Detroit 48226
Penner, David A.......18530 Grand River, Detroit 48223
Pensler, Meyer.....10151 Michigan Ave., Dearborn 48126
Percy, Donald F.....15901 Greenfield Ave., Detroit 48227
Perdue, Grace M.....3011 W. Grand Blvd., Detroit 48202
Perez-Borja, Carlos......951 E. Lafayette, Detroit 48207
Perez-Gurri, Jose L.......3150 Carpenter, Detroit 48212
Perez-Teran, Rene........3033 Carpenter, Detroit 48212
Perkin, Frank S.....3011 W. Grand Blvd., Detroit 48202
Perlis, Hyman L. (L).......10 Peterboro, Detroit 48201
Perlis, Marvin S.......1030 Fisher Bldg., Detroit 48202
Perry, Harold...............Sinai Hosp., Detroit 48235
Perry, Joseph H......259 Lewiston Rd., Grosse Pte. 48236
Petermann, Claus....21421 Kelly Rd., East Detroit 48021
Peters, Wm. R.....12400 E. Seven Mile Rd., Detroit 48205
Peterson, Gustav.............Fisher Body, Willow Run, Ypsilanti 48197
Peterson, Robert A.....18700 Meyers Rd., Detroit 48235
Petoskey, Edward A.........5656 W. Fort, Detroit 48209
Petrick, Thos. J.......15101 Southfield, Allen Park 48101
Petrini, Mario A.........1080 Fisher Bldg., Detroit 48202
Petrucco, Louis A...........14044 W. McNichols Rd., Detroit 48235
Petty, Thos. A...17300 E. Jefferson Ave., Grosse Pte. 48236
Petz, Arthur John....36000 Five Mile Rd., Livonia 48154
Petz, Thomas J...1139 Dav. Whitney Bldg., Detroit 48226
Peven, Philip S.........18709 Meyers Rd., Detroit 48235
Phillips, Burton E...........5050 Joy Rd., Detroit 48204
Picard, Jos. D.......5237 Oakman Blvd., Dearborn 48126
Piccone, Louisa I.......17700 W. Warren, Detroit 48228
Pichette, J. Walton..6650 Greenfield Rd., Dearborn 48126
Pickard, Orlando W. (L)..........14300 W. McNichols, Detroit 48235
Pickering, L. M.........15830 Fort St., Southgate 48192
Pierce, James M., Jr...Wayne St. University, Detroit 48202
Pietra, A. W. (L).....1176 Bishop, Grosse Pointe 48230
Piggott, Leonard R.......951 E. Lafayette, Detroit 48207
Piligian, John T...........3825 Brush St., Detroit 48201
Pingel, James F..........998 Norfolk, Birmingham 48009
Pink, Rose M.......11413 Joseph Campau, Detroit 48212
Pino, Ralph H. (L)..........48151 W. Ann Arbor Rd., Plymouth 48170
Piper, Ralph R...........1495 McKinstry, Detroit 48209
Pittman, John E. (L)............1553 Woodward Ave., Detroit 48226
Pitts, Kenneth E........600 Middlesex, Grosse Pte. 48236

Platz, Carol K.....612 Est. Cen. Prof. Bldg., Detroit 48236
Plavnick, Herman M........13300 Fenkell, Detroit 48227
Pliskow, Harold............15901 W. 9 Mile Rd., #202, Southfield 48075
Plotnick, Harold..........18654 Muirland, Detroit 48221
Plous, Eugene I..........569 Fisher Bldg., Detroit 48202
Podolsky, Harold M.......3755 Fort, Lincoln Park 48146
Pogrebniak, A.........25210 Grand River, Detroit 48240
Poim, Senta V...........1069 Fisher Bldg., Detroit 48202
Polentz, Chas. P.....31815 Southfield, Birmingham 48009
Polk, John E...............8721 12th St., Detroit 48206
Pollack, Jerome L.....14551 Southfield, Allen Park 48101
Pollack, John J.....15901 W. 9 Mile Rd., Southfield 48075
Pollard, R. J..................Grace Hosp., Detroit 48201
Pollens, Louis S...12730 W. McNichols Rd., Detroit 48235
Pollina, Clement J...21503 Harper, St. Clair Shores 48080
Ponka, Jos. L........2799 W. Grand Blvd., Detroit 48202
Pool, Walter D.........20901 Moross Rd., Detroit 48236
Pope, Gerald........Henry Ford Hospital, Detroit 48202
Porretta, Chas. A.............507 Northland Med. Bldg., Southfield 48075
Porretta, Francis S................18591 Saratoga Blvd., Lathrup Village 48075
Porretta, George F.....20905 Greenfield, Southfield 48075
Porter, Fredk. G.........29590 Five Mile, Livonia 48154
Porter, Howard J. (A)..................2555 S.E. 7th, Pompano Beach, Fl. 33062
Portnoy, Harry.........24710 Sussex Ave., Detroit 48237
Posch, Jos. L............1410 Kales Bldg., Detroit 48226
Posner, Irving........18111 Muirland Ave., Detroit 48235
Postigo, Julio C.......275 W. Grand Blvd., Detroit 48216
Potts, Elihue B...............7404 Dexter, Detroit 48206
Potts, Maurice B. (A)........Grace Hosp., Detroit 48201
Powaser, Joseph T..................26904 Wilson Dr., Dearborn Heights 48127
Poznanski, Andrew K............Univ. Hosp. Radiology, Ann Arbor 48104
Pracher, John R........3815 Pelham Rd., Dearborn 48124
Prasad, Ananda S...Wayne State University, Detroit 48207
Prasad, Prem S....41001 W. 7 Mile Rd., Northville 48167
Pratt, Jean P. (L)....18910 Fairway Dr., Detroit 48221
Pratt, Lawrence A. (A)............U.S. A.I.D. P.H. E., A.P.O. 96243, San Francisco, Ca.
Preston, Ruth E.....3011 W. Grand Blvd., Detroit 48202
Price, A. Hazen (L)..18605 Birchcrest Ave., Detroit 48221
Price, Alvin E.......1553 Woodward Ave., Detroit 48226
Price, Scott K..........Oakwood Hosp., Dearborn 48124
Priest, Robt. J..........Henry Ford Hosp., Detroit 48202
Prince, Addison E............8942 Dexter, Detroit 48206
Prisbe, Edward J.....16603 Plymouth Rd., Detroit 48227
Priver, Julien..........6741 W. Outer Dr., Detroit 48235
Procailo, Alexander B...29901 Ford Rd., Garden City 48135
Proctor, J. Laurence (A)..............5935 Middlesex, Dearborn 48126
Proctor, Leonard R.....3815 Pelham Rd., Dearborn 48124
Proctor, Lorne D.......Henry Ford Hosp., Detroit 48202
Prokop, Frank P....12740 S. Marrow St., Dearborn 48126
Prokopowycz, V............19666 Conant, Detroit 48234
Proskey, Aloysius J. (A)............16167 Glastonbury, Detroit 48219
Proud, Russel F...26151 Huron River Dr., Flat Rock 48134
Prus, A. Michael......4160 John R Street, Detroit 48201
Prust, Frank W.............1536 David Whitney Bldg., Detroit 48226
Prystowsky, S................1800 Tuxedo, Detroit 48206
Przybylski, Thom. J.......770 Fisher Bldg., Detroit 48202
Pugel, Andre,............VA Hospital, Allen Park 48101
Pugel, Josephine..Detroit Memorial Hosp., Detroit 48226
Pugh, Howard C.....1553 Woodward Ave., Detroit 48226
Pugliesi, Angelo........9489 E. Outer Dr., Detroit 48213
Pugliesi, Benedetto (L)..9489 E. Outer Dr., Detroit 48213
Purcell, Frank H. (L)....10 Witherell St., Detroit 48226
Puro, Henry E..........1733 Trenton Dr., Trenton 48183
Pursel, Stewart E........1016 Prof. Plaza, Detroit 48201
Purves, W. L.............17595 Parkside, Detroit 48221
Quigley, Eugene H.....................635 N. Gulley, Dearborn Hghts. 48127
Quigley, Wm. G.........1075 Fisher Bldg., Detroit 48202
Quinn, Edward L......1141 Golfview, Birmingham 48009
Quinones, Rafael E.......17200 E. Warren, Detroit 48224

Rabinovitch, Bella M.............26590 Wellington Dr., Franklin 48025
Raby, Naim M.............15830 Fort, Southgate 48192
Rachmaninoff, N...........Harper Hosp., Detroit 48201
Radgens, Paul D.........751 S. Military, Dearborn 48124
Ragheb, Samir...........4407 Roemer, Dearborn 48126
Rahm, Lambert P...14411 E. Jefferson Ave., Detroit 48215
Raiford, Frank P., Jr.........9107 12th St., Detroit 48206
Raikes, James A..........6309 Charlevoix, Detroit 48207
Ralyea, Imbi.........22700 Garrison 1103, Dearborn 48124
Ramos, Herminio R.......9801 Conant, Hamtramck 48212
Ramsey, Robt. H...........3815 Pelham, Dearborn 48124
Randall, David S.......3955 Fort St., Lincoln Park 48146
Rapoport, Bernard..........1800 Tuxedo, Detroit 48206
Rapp, Seymour L...22711 Wrexford Dr., Southfield 48075
Rasimas, Carl A.........1210 Kales Bldg., Detroit 48226
Raskin, Herbert A.....18510 Meyers Road, Detroit 48235
Rastello, Peter B. (R)............3295 West Shore Dr., Orchard Lake 48033
Rattner, Wm. H...1355 Dav. Whitney Bldg., Detroit 48226
Rau, Fredk. W......3790 Woodward Ave., Detroit 48201
Raven, Clara............400 E. Lafayette, Detroit 48226
Ravin, Herbert A.......6767 W. Outer Dr., Detroit 48235
Ravitz, Louis A........23350 Thorncliff, Southfield 48075
Ray, Kenneth J........28059 Elba Dr., Grosse Ile. 48138
Raynor, Harold F. (L)....49 Virginia Pk., Detroit 48202
Razi, Massoud............1214 S. Wayne, Wayne 48184
Rebandt, Raymond W...2615 W. Jefferson, Trenton 48183
Rebuck, John W.....2799 W. Grand Blvd., Detroit 48202
Redding, Foster K...Henry Ford Hospital, Detroit 48202
Redding, Lowell G................1336 Southfield Rd., Lincoln Park 48146
Reder, Benjamin..17301 W. Eight Mile Rd., Detroit 48235
Redfern, W. Earl....2799 W. Grand Blvd., Detroit 48202
Reed, Ivor E. (L)............25579 Loch Lomond Dr., Dearborn 48125
Reed, Joseph O., Jr...........448 Lincoln, Detroit 48230
Reed, Melvin L...........4160 John R St., Detroit 48201
Rees, Howard C. (L)....15700 Mack Ave., Detroit 48224
Reese, James R.........Ford Motor Co., Dearborn 48127
Reichert, Carl E...18412 Mack Avenue, Grosse Pte. 48236
Reid, John G.......1553 Woodward Ave., Detroit 48226
Reid, Wesley G...34186 Sprg. Valley Dr., Westland 48185
Reidt, William U............1800 Tuxedo, Detroit 48206
Reiff, Morris V.............10241 Joy Rd., Detroit 48204
Reinhard, Richard E.............7815 E. Jefferson Ave., Detroit 48214
Reinsh, Ernest R...600 Trailwood Path, Birmingham 48010
Reisig, Robert O.............20867 Mack, Detroit 48236
Reisman, Saml. G.....1553 Woodward Ave., Detroit 48226
Reive, David L. E. (A)...25447 Plymouth, Detroit 48239
Remski, James E........29447 Ravine Dr., Livonia 48152
Reno, George L..........970 Fisher Bldg., Detroit 48202
Rentenbach, Robt. F..........314 David Whitney Bldg., Detroit 48226
Resto, Manuel.........21955 Wildwood, Dearborn 48128
Resto Soto, A. D........17644 W. Warren, Detroit 48228
Reveno, Wm. S. (L)..3001 W. Grand Blvd., Detroit 48202
Reyner, Clarence E. (L)..10 Peterboro St., Detroit 48201
Reynolds, Robt. M.......856 Fisher Bldg., Detroit 48202
Rezanka, Harold J....1553 Woodward Ave., Detroit 48226
Rhoades, Francis P.............2414 16 Broderick Twr., Detroit 48226
Rice, Harold B...........10 Peterboro St., Detroit 48201
Rice, Meshel (R)..........533 Coats Rd., Oxford 48051
Rice, William J....550 Eastland Prof. Bldg., Detroit 48236
Richards, M. A...........6309 Charlevoix, Detroit 48207
Rick, Paul J. (A)............12673 Joan, Detroit 48205
Riddell, Wilfred A...15420 Farmington Rd., Livonia 48154
Rideout, Richard A...6071 W. Outer Drive, Detroit 48235
Rieckhoff, Geo. G. (L)..........14905 E. Jefferson Ave., Detroit 48215
Rieden, James A..........18053 Muirland, Detroit 48221
Rieger, John B. (L).........746 Pallister, Detroit 48202
Rieger, Mary H. (L)...............19285 Lucerne Dr., Highland Park 48203
Riethmiller, Robt. F...........12444 E. Seven Mile Rd., Detroit 48203
Rinaldo, Joseph, Jr.........6071 Outer Dr., Detroit 48235
Rinkel, Robert W.......7319 Park Ave., Allen Park 48101
Ritter, George....28245 Southfield, Lathrup Village 48075

Rivera, Emiliano, Jr..........1800 Tuxedo, Detroit 48206
Rizzo, Paul............38 Warner Rd., Grosse Pte. 48236
Robb, Edward L. (L).........15801 W. McNichols Rd., Detroit 48235
Robb, Herbert J.......2706 Comfort, Birmingham 48010
Roberts, Arthur J. (R).................859 Winchester, Lincoln Park 48146
Roberts, George A.......7220 Gratiot Ave., Detroit 48213
Robin, Erwin........Wayne State Univ., Detroit 48207
Robinson, Harold A...........16240 W. 12 Mile Road, Southfield 48075
Robinson, Howard........953 Fisher Bldg., Detroit 48202
Robinson, James H., Jr.......10440 W. Seven Mile Rd., Detroit 48221
Robinson, Remus G.........3751 31st St., Detroit 48210
Rodin, Ernst A..........951 E. Lafayette, Detroit 48207
Rodriquez, Ana G..Detroit Memorial Hosp., Detroit 48226
Roehl, Karl H.......1800 Grindley Park, Dearborn 48124
Rogers, Aaron Z.........20451 Mack Ave., Detroit 48236
Rogers, Geo. E. B...8425 Twelve Mile Rd., Warren 48093
Rogers, John T.......29586 Five Mile Rd., Livonia 48154
Rogers, Robert P...........14200 Puritan, Detroit 48227
Rogoff, Abraham S. (L)....17000 W. Eight Mile Rd., Southfield 48075
Rohde, Paul C. (L)...12282 E. Outer Dr., Detroit 48224
Rohl, Dieter J.........St. Marys Hospital, Livonia 48150
Rojas, Leonidas.........2141 E. Jefferson, Detroit 48207
Rollocks, Hugh W. 7441 W. Seven Mile Rd., Detroit 48221
Roman, Stanley J...15020 Michigan Ave., Dearborn 48126
Romanski, Raymond...........16001 W. Nine Mile Rd., Southfield 48075
Romero, Carlos P., Jr.......3105 Carpenter, Detroit 48212
Ronayne, John J., Jr...........16345 W. McNichols Rd., Detroit 48235
Rood, Robert C.........25909 Schoolcraft, Detroit 48239
Root, Fayette C.....719 New Center Bldg., Detroit 48202
Rosbolt, James F.......8505 Plymouth Rd., Detroit 48204
Rosbolt, O. Paul, Jr.....8505 Plymouth Rd., Detroit 48204
Rose, Arthur.................7401 Third, Detroit 48202
Rosen, Harold M...8620 W. McNichols Rd., Detroit 48221
Rosen, Theodore S...17120 New Jersey, Southfield 48075
Rosenbaum, Herbert......18110 Muirland, Detroit 48221
Rosenberg, Irwin K..................Dept. of Surgery, 1400 Chrysler Freeway, Detroit 48207
Rosenberg, Jerry C...1400 Chrysler Expwy., Detroit 48207
Rosenbloom, Alvin B.......17555 Parkside, Detroit 48221
Rosenblum, Saul A.....Henry Ford Hosp., Detroit 48202
Rosenthal, Albert....27855 Plymouth Rd., Livonia 48150
Rosenthal, Louis H...15401 W. McNichols, Detroit 48235
Rosenthal, Saml.............8844 Joy Rd., Detroit 48204
Rosenwach, Felix F...........19149 W. Seven Mile Rd., Detroit 48219
Rosenzweig, Norman...6767 W. Outer Dr., Detroit 48235
Rosenzweig, Saul.........2542 W. Boston, Detroit 48206
Ross, Arthur J...........18215 Greenfield, Detroit 48235
Ross, Charles V...........7740 Da Costa, Detroit 48239
Ross, Mervyn B...........9559 Greenfield, Detroit 48227
Ross, Robert R. (A).Detroit Gen. Hospital, Detroit 48226
Rota, Alexander N...........Sinai Hosp., Detroit 48235
Rotarius, Edward M......Parke Davis Co., Detroit 48232
Roth, Edward T. (L)..640 E. Grand Blvd., Detroit 48207
Rother, Ina A. C.......101 Chicago Blvd., Detroit 48202
Rothwell, Walter S.........2730 Chelsea, Trenton 48183
Rottenberg, Coleman M. J...13419 Fenkell, Detroit 48227
Rottenberg, E. N.............20725 W. Seven Mile Rd., Detroit 48219
Rottenberg, Leon......13419 Fenkell Ave., Detroit 48227
Rotter, Norman J...3333 E. Jefferson Ave., Detroit 48207
Roubeck, William............17000 W. Eight Mile Rd., Southfield 48075
Rowda, Michael S.....7 Cambridge, Pleasant Ridge 48069
Rowe, Jos. J., Jr..........401 N. Brady, Dearborn 48124
Roy, L. James..........1210 Kales Bldg., Detroit 48226
Royer, Richard R....18101 E. Warren Ave., Detroit 48224
Rubenstein, Alfred I...Sinai Hospital, 6767 Outer Dr. W., Detroit 48235
Rubinoff, William............22341 W. Eight Mile Rd., Detroit 48219
Rubio, Epimaco............26612 Karen, Warren 48091
Ruble, Paul E...1139 David Whitney Bldg., Detroit 48226
Ruch, Newton C..Mt. Carmel Mercy Hosp., Detroit 48235
Rudner, Earl J...........15901 W. Nine Mile Rd., #620, Southfield 48075
Ruedemann, Albert D.............1633 David Whitney, Detroit 48226
Ruedemann, Albert D., Jr.......1633 Dav. Whitney Bldg., Detroit 48226
Rueger, Milton J...717 Dav. Whitney Bldg., Detroit 48226
Rueger, Ralph C....9149 E. Jefferson Ave., Detroit 48214
Ruel, Richard E...33750 Freedom Rd., Farmington 48024
Ruiz, Luis C...........1678 Merriann Rd., Wayne 48184
Rule, Jack A. (A)...Detroit General Hosp., Detroit 48226
Runge, Edward F. (A)...........8295 39th Avenue N., St. Petersburg, Fl. 33709
Rupe, Clarence E....2799 W. Grand Blvd., Detroit 48202
Rupprecht, Emil F...15901 Greenfield Rd., Detroit 48227
Rusciano, Emilio............Grace Hosp., Detroit 48201
Rush, Desmond K.............1429 Dav. Whitney Bldg., Detroit 48226
Ruskin, Robert L...........Sinai Hospital, Detroit 48235
Ruskin, Saml. H. (L).............15901 W. 9 Mile Rd., Southfield 48075
Russanow, Georg........400 E. Lafayette, Detroit 48226
Russell, Henry N., Jr...15101 Southfield, Allen Park 48101
Rutherford, Isobel..Detroit Memorial Hosp., Detroit 48226
Ruzumna, Richard A. (M)...........602 H Street S.W., Washington, D.C. 20024
Ryan, James M..........16888 Greenfield, Detroit 48235
Ryan, William D. (R).....................Box 10931, St. Petersburg, Fl. 33733
Sabbagh, Enrique....2605 W. Grand Blvd., Detroit 48208
Sack, Anthony G.......18230 Grand River, Detroit 48223
Sa'di, Lutfi M. (L)......10 Peterboro St., Detroit 48201
Sadler, Henry H., Jr. (N)............12 Tamalpais Rd., Belvedere, Ca. 94920
Sadusk, Joseph F...................Parke, Davis & Co., Jos. Campau at the River, Detroit 48232
Sadzikowski, Jos. T...29901 Ford Rd., Garden City 48135
Saeed, Sheikh M......Henry Ford Hospital, Detroit 48202
Sage, Bernard A......210 Woodcrest Dr., Dearborn 48124
Sager, Edward L. (L)..13902 Gratiot Ave., Detroit 48205
St. Amour, Hector J. (L)........25515 Blossingham Dr., Dearborn Hghts. 48127
Sakorraphos, S. N. (L)..............66 Crestview Rd., Belmont, Ma. 02178
Sakwa, Saul..17000 W. Eight Mile Rd., Southfield 48075
Salamon, Fredk. A. 6878 Alderley Way Birmingham 48010
Salan, Lacy J..........1257 S. Main St., Plymouth 48170
Salazar, Fernando N.....2645 Grange Rd., Trenton 48183
Salchow, Paul T............8285 Hartwell, Detroit 48228
Salciccioli, Gino G...3930 E. Eight Mile Rd., Detroit 48234
Salem, Edward S.............22420 Twyckingham Way, Southfield 48075
Salhaney, Mitchell......15252 Levan Rd., Livonia 48154
Sall, Caroline D...........6246 Chase, Dearborn 48126
Sallee, William T.....17000 W. 8 Mile, Southfield 48075
Salot, William H...220 Eastland Prof. Bldg., Detroit 48236
Saltzstein, Harry C. (L)....850 Whitmore, Detroit 48203
Salva, Donald L......3675 E. Outer Drive, Detroit 48234
Salvaggio, A. T.................426 Eastland Prof. Bld., Harper Woods 48236
Samberg, L. Carl........1210 Kales Bldg., Detroit 48226
Samovitz, Myron (A).........6960 Telegraph, Apt. 121, Birmingham 48010
Sand, Harry H............24110 Oxford, Dearborn 48124
Sandberg, Hershel.........19207 Schaefer, Detroit 48235
Sander, Irvin W. (R)...........801 W. Long Lake Rd., Bloomfield Hills 48013
Sanderson, Alvord R. (L)...........978 Pemberton Rd., Grosse Pte. 48230
Sandler, Nathaniel............15901 W. Nine Mile Rd., Southfield 48075
Santino, Alphonse M. (M)......208 Eastland Prof. Bldg., Detroit 48236
Santos, Delfin F........18101 Oakwood, Dearborn 48124
Sapala, M. Andrew..............21471 Cherry Hill Rd., Dearborn 48124
Sargent, Douglas A..................816 Grand Marais, Grosse Pte. Park 48236
Sargent, Richard C......17357 Fenkell St., Detroit 48227
Sargent, William R......17357 Fenkell St., Detroit 48227
Sarmiento, Manuel...15600 Pennsylvania, Southfield 48075

Sarracino, John B. (A).......U.S. Army Hosp., Vicenza, A.P.O., New York, N.Y. 09221
Sauk, John J........302 W. McNichols Rd., Detroit 48203
Saulsberry, Guy O.......4059 W. Davison, Detroit 48238
Saunders, Gene A...10933 Farmington Rd., Livonia 48150
Sauter, Simon H. (L)..1082 E. Grand Blvd., Detroit 48207
Sawdyk, Daria H.........7012 Mich. Ave., Detroit 48210
Sazyc, Joseph S.........22101 Moross Rd., Detroit 48236
Scarney, Herman D...3011 W. Grand Blvd., Detroit 48202
Schaefer, H. C..........7815 E. Jefferson, Detroit 48214
Schaefer, Robt. L. (A)..76 W. Adams Ave., Detroit 48226
Schaefer, Robt. L., Jr. ......74 W. Adams, Detroit 48226
Schaeffer, J. N................261 Brady, Detroit 48201
Schaeffer, Martin......16186 Oxley Rd., Southfield 48075
Schakne, Norman........669 Fisher Bldg., Detroit 48202
Schane, David A.........19159 Berkeley, Detroit 48221
Schatten, Ivan C.....14607 E. Seven Mile, Detroit 48205
Schatz, Irwin J.....1400 Chrysler Expwy., Detroit 48207
Scheer, Alan C.....Detroit Memorial Hosp., Detroit 48226
Schembeck, Isaac S. (L)..........1553 Woodward Ave., Detroit 48226
Scherer, Robert A.........470 Fisher Bldg., Detroit 48202
Schidlowsky, Oleg P...29594 Five Mile Rd., Livonia 48154
Schiller, Arthur E. (L)...........1553 Woodward Ave., Detroit 48226
Schirack, Raymond D. (R)..............Luzerne 48636
Schkloven, Norman.....20051 Warrington, Detroit 48221
Schlafer, Nathan H.......10 Witherell St., Detroit 48226
Schlesinger, Henry..13534 Woodward Ave., Detroit 48203
Schmaltz, John D.............1701 Dav. Whitney Bldg., Detroit 48226
Schmidt, George J......7106 Park Ave., Allen Park 48101
Schmidt, Harry E.........667 Fisher Bldg., Detroit 48202
Schmidt, Johann.........7815 E. Jefferson, Detroit 48214
Schmidt, Klaus P......871 Fisher Building, Detroit 48202
Schmidt, Werner F.......1807 Stroh Bldg., Detroit 48226
Schmier, Burton L. (A)............42659 Five Mile Rd., Plymouth 48170
Schmitt, Norman L............10127 W. McNichols Rd., Detroit 48221
Schneck, Robt. J.....1553 Woodward Ave., Detroit 48226
Schneider, Chas. L...22148 Michigan Ave., Dearborn 48124
Schneider, Curt P........655 Fisher Bldg., Detroit 48202
Schneider, John R....15001 W. 8 Mile Rd., Detroit 48235
Schoenfield, Gilbert D...........8830 W. McNichols Rd., Detroit 48221
Scholdager, Rolf H...........1800 Tuxedo, Detroit 48206
Schooff, Kenneth G......951 E. Lafayette, Detroit 48207
Schooten, Sarah S. (L)......15901 W. 9 Mile Rd., #214, Southfield 48075
Schorer, Calvin E........951 E. Lafayette, Detroit 48207
Schroeder, Carlisle F...............26505 E. River Rd., Grosse Ile 48138
Schroeder, Gisela..22408 Park Lane, St. Clair Shores 48080
Schroeder, Heinz R..............1941 Hawthorne Blvd., Dearborn 48128
Schroeder, Karl F...7815 E. Jefferson Ave., Detroit 48215
Schuchter, S. L.............1800 Tuxedo, Detroit 48206
Schulte, Carl H. (L) 717 Redding Rd., Birmingham 48009
Schultz, Clarence H...23100 Cherry Hill, Dearborn 48124
Schultz, Donald V.....23100 Cherry Hill, Dearborn 48124
Schultz, Ernest C. (L)...........1553 Woodward Ave., Detroit 48226
Schultz, E. C., Jr.............610 N. Woodward Ave., Birmingham 48011
Schuman, Bernard M...Henry Ford Hospital, Detroit 48202
Schwartz, Benj........275 W. Grand Blvd., Detroit 48216
Schwartz, Harold A............15201 W. McNichols Rd., Detroit 48235
Schwartz, Louis A. (A)................P. O. Box 315, Rockport, Ma. 01966
Schwartzberg, J. A.........19445 Plymouth, Detroit 48228
Schwarz, Alvin D..............16965 Geo. Washington, Southfield 48075
Schwarz, Frank W....23100 Cherry Hill, Dearborn 48124
Schweigert, C. F.......10627 Cadieux Rd., Detroit 48224
Schwimmer, Benjamin 27855 Plymouth Rd., Livonia 48150
Sciarrino, Stanley V. (L).........16190 James Couzens, Detroit 48221
Scott, Marrion U........20170 Mack Ave., Detroit 48236
Scott, Wm. J. (L).................20170 Mack Ave., Grosse Pte. Woods 48236
Scratch, Gordon P......1005 Mutual Bldg., Detroit 48226
Screen, Raymond J...........18520 W. Seven Mile Rd., Detroit 48219
Seabrooks, F. A.........726 Lothrop St., Detroit 48202
Segal, Andrew E.....19481 Livernois Ave., Detroit 48221
Segar, Laurence F.....998 Church St., Ventura, Ca. 93001
Segel, Nathan P.............19100 Manor, Detroit 48221
Seibert, Alvin H. (L)................1180 Bedford Rd., Grosse Pte. Park 48230
Seiferlein, A. L..........1067 Devonshire, Detroit 48230
Seim, Elmer J...............Grace Hosp., Detroit 48201
Seitam, Karl......10149 Michigan Ave., Dearborn 48126
Selbst, Ronald A...................26339 Woodward, Huntington Woods 48070
Self, Wm. G.........20861 Mack Ave., Grosse Pte. 48236
Selim, Mahmoud M...8425 E. 12 Mile Rd., Warren 48093
Sellers, Chas. W. (L)...........18545 Schoolcraft Ave., Detroit 48223
Sellers, Graham A. (A).......10535 W. Seven Mile Rd., Detroit 48221
Seltzer, Joseph........20905 Greenfield, Southfield 48075
Selzer, Isidore....1151 Taylor, Labs. Dept., Detroit 48202
Senecoff, Stephen D.....18055 Greenfield, Detroit 48235
Sepetys, Povilas........25466 Clairview, Dearborn 48124
Seski, Arthur G.........1069 Fisher Bldg., Detroit 48202
Severyn, Fred R.........15830 Fort St., Southgate 48192
Sewell, Geo. (L)..31801 Arlington Dr., Birmingham 48009
Sewell, Guy W....17751 East Warren Ave., Detroit 48224
Shaalan, A. Karim.......Doctor's Hospital, Detroit 48207
Shafadeh, Asghar..........28303 Joy Rd., Westland 48185
Shafarman, Eugene M.....3790 Woodward, Detroit 48201
Shaffer, Jos. H......2401 Radnor Dr., Birmingham 48009
Shaffer, Loren W. (R)............Villa Flora, Apt. 331, 2871 N. Ocean Blvd., Boca Raton, Fl. 32432
Shafter, Royce R........1188 Puritan, Birmingham 48009
Shams-Avari, Parviz....27584 Schoolcraft, Livonia 48150
Shanoski, Stanley J...........1910 Dav. Broderick Twr., Detroit 48226
Shapiro, H. S.....19630 W. McNichols Rd., Detroit 48219
Shapiro, Jack.......22669 Glastonbury, Southfield 48075
Shapiro, Reuben I....22341 W. 8 Mile Rd., Detroit 48219
Shaptini, Elias A.....1 Woodward Avenue, Detroit 48226
Shargel, Geo. M. J...........1800 Tuxedo, Detroit 48206
Sharp, Elwood A. (A)...633 Neff Rd., Grosse Pte. 48230
Sharpe, Wm. D...24621 W. McNichols Rd., Detroit 48219
Sharrer, Chas. H....................1133 Grayton Rd., Grosse Pte. Park 48230
Shartsis, Jack......Detroit General Hosp., Detroit 48226
Shea, Francis P.............Harper Hosp., Detroit 48201
Shecter, Harry........2200 E. Grand Blvd., Detroit 48211
Sheehan, Irene C.......15520 Garfield, Allen Park 48101
Sheehan, Shelia......3011 W. Grand Blvd., Detroit 48202
Sheinberg, Philip (A)............Ophthalmology Dept., Detroit General Hosp., Detroit 48226
Shekerjian, Armen..........13815 Puritan, Detroit 48227
Shelden, Warren E...........14215 W. McNichols Rd., Detroit 48235
Shelfoon, Dolores J.....20101 Briarcliff Rd., Detroit 48221
Sherman, Marvin....20101 James Couzens, Detroit 48235
Sherman, Wm. L., Jr. (A)....201 E. Kirby, Detroit 48201
Sherrin, Edgar R.....19021 W. McNichols, Detroit 48219
Shevin, Frederick F.......671 Fisher Bldg., Detroit 48202
Shewchuk, A. P.........7300 Allen Rd., Allen Park 48101
Shields, Wm. L...............510 Hildale, Detroit 48203
Shiffman, Milton M.....Mt. Sinai Hospital, Detroit 48235
Shifrin, Peter G.............3535 W. 13 Mile, No. 507, Royal Oak 48072
Shiovitz, Louis.......5419 Michigan Ave., Detroit 48210
Shipton, Waldo H. (A).............1875 8th St. South, Naples, Fl. 33940
Shlain, Benj. (A).........19280 Berkeley, Detroit 48221
Shors, Clayton M...20861 Mack, Grosse Pte. Woods 48236
Shortz, Gerald (A)..................Route 2, Box 19, Vero Beach, Fl. 32960
Shreve, Alfred J.....4520 Firestone Ave., Dearborn 48126
Shuey, John M.............17198 Oak Dr., Detroit 48221
Shufro, Arthur S...28585 Rivercrest Dr., Southfield 48075
Shulman, Herschel A...........207 Northland Med. Bld., Southfield 48075

Shumaker, Edward J.......75 Lothrop, Grosse Pte. 48236
Siddall, Roger S. (L)..3011 W. Grand Blvd., Detroit 48202
Sieber, Edward H...6650 Greenfield Rd., Dearborn 48126
Siebert, William E.............23023 Orchard Lake Rd., Farmington 48024
Siefert, John L. (R)....P.O. Box 601, Jupiter, Fl. 33458
Siegel, Henry..........19720 Chesterfield, Detroit 48221
Siero, Jose M.............9105 Van Dyke, Detroit 48213
Sievers, Lorraine A............1457 David Whitney Bg., Detroit 48226
Sigler, John W.........Henry Ford Hosp., Detroit 48202
Signori, Enrique E....29901 Ford Rd., Garden City 48135
Silbergleit, Allen....1400 Chrysler Expwy., Detroit 48207
Sill, Jacob A...20861 Mack Ave., Grosse Pte. Woods 48236
Siller, John J......17000 W. 8 Mile Rd., Southfield 48075
Sillery, Robt. J..........460 Lakeland, Grosse Pte. 48236
Sills, Richard D.....5675 Forman Dr., Birmingham 48010
Sills, William G..........19321 Greenfield, Detroit 48235
Silva, Romulo E.......Henry Ford Hosp., Detroit 48202
Silvarman, Israel Z....9105 Van Dyke Ave., Detroit 48213
Silver, Israel W.......20000 W. Chicago, Detroit 48228
Silver, Robert R......28806 Stellvalley, Farmington 48024
Silverman, Maurice M..........17301 W. Eight Mi. Rd., Detroit 48235
Silverman, Max......2240 W. Grand Blvd., Detroit 48208
Silverstein, M. E...952 Dav. Whitney Bldg., Detroit 48226
Silverstein, O. D...17000 W. 8 Mile Rd., Southfield 48075
Simmons, Donald R.......529 Fisher Bldg., Detroit 48202
Simon, Heinz G...........12206 Morang, Detroit 48224
Simpson, Gordon E...18101 E. Warren Ave., Detroit 48224
Simson, Clyde B.........951 E. Lafayette, Detroit 48207
Singer, Floyd W.........24441 Emerson, Dearborn 48124
Sinkoff, Jean....19105 W. Seven Mile Rd., Detroit 48219
Sippola, Geo. W. (L)..13603 La Salle Blvd., Detroit 48238
Sivak, B. J........24665 Santa Barbara, Southfield 48075
Sklar, Manuel.........18400 Schaefer Rd., Detroit 48235
Skully, Edward J.........14000 Linnhurst, Detroit 48205
Sladen, Frank J. (L)....Henry Ford Hosp., Detroit 48202
Slaughter, Fred M. (L)...2562 Ferry Park, Detroit 48208
Slazinski, Leo W. (L)..7618 Michigan Ave., Detroit 48210
Slevin, John G.....................1132 Whittier Ave., Grosse Pte. Park 48236
Sliwin, Edward P.....13244 W. Warren, Dearborn 48126
Slusky, Jos...............854 Fisher Bldg., Detroit 48202
Sly, Robt. F.........2101 Monroe Blvd., Dearborn 48124
Small, Harvey O. J.....3930 E. 8 Mile Rd., Detroit 48234
Small, Henry....15300 W. McNichols Rd., Detroit 48235
Small, John................19223 Conant, Detroit 48234
Smathers, Homer M...17620 W. McNichols, Detroit 48235
Smathers, Ward M...17620 W. McNichols, Detroit 48235
Smeck, Arthur R. (L)............1036 Waterman Ave., Detroit 48209
Smiggen, James J.................15901 W. 9 Mile Rd., Southfield 48075
Smith, Andrew J., Jr.......2950 Puritan, Detroit 48238
Smith, Douglas H.......10151 Michigan, Dearborn 48126
Smith, Henry L. (L)..........16401 Grand River Ave., Detroit 48227
Smith, J. Allen........14140 Puritan Ave., Detroit 48227
Smith, Richard H...........5050 Joy Rd., Detroit 48204
Smith, Richmond W., Jr...........2799 W. Grand Blvd., Detroit 48202
Smith, Roger F.................28400 W. Sunset Blvd., Lathrup Village 48075
Smith, Thomas A. (A)..........Detroit General Hosp., Detroit 48226
Smith, W. Pierce.......Henry Ford Hosp., Detroit 48202
Smyka, Stanley M.......15731 Glenwood, Detroit 48205
Snider, Eugene A......20905 Greenfield, Southfield 48075
Snider, Thomas H.........V.A. Hospital, Dearborn 48121
Snoke, Edwin C...........2901 West Rd., Trenton 48183
Snow, Linwood W. (L) 502 W. Main St., Northville 48167
Snyder, Richard J.....33433 Six Mile Rd., Livonia 48152
Sobel, Robt. A...........20211 Greenfield, Detroit 48235
Soble, Allen R.....17000 W. 8 Mile Rd., Southfield 48075
Soderberg, Ralph B...7815 E. Jefferson Ave., Detroit 48214
Soifer, Sidney.............Sinai Hospital, Detroit 48235
Sokol, Wm. M...15901 W. Nine Mile Rd., Southfield 48075
Sokolov, Raymond A...3011 W. Grand Blvd., Detroit 48202
Sokolowski, A. H.....20445 Van Dyke Ave., Detroit 48234
Solberg, Lincoln E........2021 Monroe, Dearborn 48124
Soler, Frank J...........25447 Plymouth, Detroit 48239
Soleymani, Sion............4400 Livernois, Detroit 48210
Soller, Alex S...........19309 Greenfield, Detroit 48235
Solomon, A. B............9559 Greenfield, Detroit 48227
Solomon, Robert J.....15101 Southfield, Allen Park 48101
Soltes, Otto P.....17000 W. Eight Mile, Southfield 48075
Somerville, Thos. H...36475 Five Mile Rd., Livonia 48154
Sonbay, Omer K...............Northville State Hospital, Northville 48167
Sonda, Lewis P. (R)............10951 Farmington Rd., Livonia 48150
Sonda, Lewis P., Jr.....5132 Allen Rd., Allen Park 48101
Songe, Robert A......Oakwood Hospital, Dearborn 48121
Sooudi, Massoud........1066 Fisher Bldg., Detroit 48202
Sorock, Milton L..........19467 Livernois, Detroit 48221
Sosa, Carlos M. A......................12960 Lincoln, Huntington Woods 48070
Sosa, Freddy R.....................Wayne State Univ., 1400 Chrysler Expwy., Detroit 48207
Speck, Carlos C........6525 Park Ave., Allen Park 48101
Speer, David L.......7024 Woodbank, Birmingham 48010
Sperry, Frederick L. (A)......2641 Golden Rain Rd., #4, Walnut Creek, Ca. 94529
Sphire, Raymond D.......4160 John R St., Detroit 48201
Spiro, Adolph S............13240 Harper, Detroit 48213
Spiwak, Bertram J..................7407 Cathedral Dr., Birmingham 48010
Springborn, Benj. R. (L)........15818 E. Warren Ave., Detroit 48224
Sprunk, Carl J....2900 Oakwood Blvd., Melvindale 48127
Spurrier, Ethelbert..................261 Kenwood Ct., Grosse Pt. Farms 48236
Squires, Walter M. (R)................1616 S. 28 Ave., St. Petersburg, Fl. 33712
Srinivasan, S................1800 Tuxedo, Detroit 48206
Stahly, Mary S................Sinai Hosp., Detroit 48235
Stair, Gerald A...Wayne County Genl. Hosp., Eloise 48132
Stalker, Hugh (R)................824 Lake Shore Rd., Grosse Pte. Shrs. 48236
Stamell, Benjamin B...........17000 W. Eight Mile Rd., Southfield 48075
Stamell, Meyer.......14634 Greenfield St., Detroit 48227
Stanton, James M. (L)..1001 Mutual Bldg., Detroit 48226
Stanton, Myron R.....7441 W. 7 Mile Rd., Detroit 48221
Stapleton, Wm. J., Jr. (L)............201 E. Kirby Ave., Detroit 48202
Starico, Renato........3783 Fort St., Lincoln Park 48146
Staryk, Steven E...............6331 N. E. 22nd Ave., Ft. Lauderdale, Fla. 33708
Statzer, Darrell E........955 Fisher Bldg., Detroit 48202
Staub, Howard P. (R).......9210 Jerome, Detroit 48239
Staudt, Louis W.........1201 Pilgrim, Birmingham 48009
Stearns, Alexander B.........7430 Second, Detroit 48202
Stebbins, Chas. E............705 Northland Med. Bldg., Southfield 48075
Steel, William B.............Hutzel Hosp., Detroit 48232
Steepe, Chas. A. D...20340 Harper, Harper Woods 48236
Stefani, Andrew E.....................471 Oxford Rd., Grosse Pte. Woods 48236
Stefani, Ernest L. (L)........18455 Jas. Couzens Hwy., Detroit 48235
Stefani, Raymond T.........13526 Stoepel, Detroit 48238
Stein, Albert H.......19334 San Juan Dr., Detroit 48221
Stein, Emory...........13115 Woodward, Detroit 48203
Stein, Harvey S...22341 W. Eight Mile Rd., Detroit 48219
Stein, Saul C...........23105 Van Dyke, Warren 48089
Steinbach, A. L...320 Merriweather Rd., Grosse Pte. 48236
Steinberger, E. J. (L)......6402 W. Fort, Detroit 48209
Steiner, Fredk. B.............29108 Ford Rd., Box 356, Garden City 48135
Steiner, S. D........3044 W. Grand Blvd., Detroit 48202
Steinhardt, Milton J.......18910 Birchcrest, Detroit 48221
Steinhauer, Bruce W.....Henry Ford Hosp., Detroit 48202
Stellhorn, Chester E...........12900 W. Seven Mile Rd., Detroit 48235
Stellhorn, Mary C. (A)..16616 Mack Ave., Detroit 48224
Stempel, Edward M...18324 Fairfield Ave., Detroit 48221
Sterba, Richard F....18228 Mack Ave., Grosse Pte. 48236
Stern, Edward A.............12700 W. Seven Mile Rd., Detroit 48235
Stern, Joseph W...15901 W. 9 Mile Rd., Southfield 48075

Stern, Julian....15121 W. McNichols Rd., Detroit 48235
Stern, Leonard H.........19200 Aften Rd., Detroit 48203
Stern, Louis D. (L)..1553 Woodward Ave., Detroit 48226
Sternhill, Vernon.............1800 Tuxedo, Detroit 48206
Stevens, Chas. H...15901 W. 9 Mile Rd., Southfield 48075
Stevenson, Chas. S.......960 Fisher Bldg., Detroit 48202
Stevenson, Lee B.......Henry Ford Hosp., Detroit 48202
Stewart, Maitland N., Jr...............20905 Greenfield, Southfield 48075
Stewart, Marjorie (A).....581 Golfcrest, Dearborn 48124
Stewart, Robert M......10933 Farmington, Livonia 48150
Stiefel, Danl. M. (L)..........1563 Dav. Whitney Bldg., Detroit 48226
Stillwater, Karl.........18221 Pennington, Detroit 48221
Stith, Dwight E............505 Owen St., Detroit 48202
Stobbe, Godfrey D...........Grace Hosp., Detroit 48201
Stock, Thomas B.....25500 Friar Lane, Southfield 48075
Stocker, Lawrence L...7310 W. 7 Mile Rd., Detroit 48221
Stocker, Marvin L.....16401 Grand River, Detroit 48227
Stockwell, Benj. W...1553 Woodward Ave., Detroit 48226
Stokfisz, Thaddeus........7012 Michigan, Detroit 48210
Stoller, Raymond..25210 Grand River Ave., Detroit 48240
Stone, Sidney L.....22790 Kelly Rd., East Detroit 48021
Stoyka, Michael R........1977 Oxford, Grosse Pte. 48236
Straith, Richard E...2605 W. Grand Blvd., Detroit 48208
Strand, Martin E...................22400 Cherry Hill, West Dearborn 48124
Stratton, Peter K.........5237 Oakman, Dearborn 48128
Strauss, Ernest G.......................67 Sunningdale, Grosse Pte. Shores 48236
Stricker, Henry D. (L)..........930 Weaver Rd., R#2, Milford 48042
Strickler, D. T., Jr. 22231 W. Outer Drive, Dearborn 48124
Strickroot, Fred L........3800 Bishop Rd., Detroit 48224
Stronski, G. E.............9901 Whittier, Detroit 48224
Stroud, James D. (A)...........Detroit General Hosp., Detroit 48226
Stryker, Joan C......21604 E. River Rd., Grosse Ile 48138
Stryker, Walter A........P. O. Box 31, Wyandotte 48192
Stubbs, Clayton T. (R).................133 S. Walnut, Mt. Clemens 48043
Stubbs, Harold W. (L)..........13930 Woodward Ave., Highland Park 48203
Subrin, Mayer..4430 Quarton Rd., Bloomfield Hills 48013
Sudakin, Leonard....10326 W. 7 Mile Rd., Detroit 48221
Suen, Irene T. S...Chrysler Corp., Box 1919, Detroit 48231
Sugar, H. Saul..........970 Fisher Bldg., Detroit 48202
Sugarman, Marcus H...15201 W. McNichols, Detroit 48235
Sugayan, Norberto A...34275 Munger Dr., Livonia 48154
Sullivan, Paul J.....................26711 Woodward, Huntington Woods 48070
Sullivan, Thomas M......951 E. Lafayette, Detroit 48207
Sultzman, L. Carl..55 Vendome, Grosse Pte. Farms 48236
Sumcad, Bernard T...2021 Monroe Blvd., Dearborn 48124
Summers, Wm. A.....1553 Woodward Ave., Detroit 48226
Sutherland, Jacob M. (L)........8900 E. Jefferson Ave., Detroit 48214
Suwinski, Raymond H................9801 Conant St., Hamtramck 48212
Swan, Donald C.............17000 W. Eight Mile Rd., Southfield 48075
Swan, Lionel F...............9245 Mack, Detroit 48214
Swanson, Carl W...........936 Alter Rd., Detroit 48215
Swanson, Robt. G.............314 Eastland Prof. Bldg., Detroit 48236
Swartz, Fred G., Jr...........1329 Dav. Whitney Bldg., Detroit 48226
Sweeny, Donald N., Jr.....8445 E. Jefferson, Detroit 48214
Switzer, Bertrand C. (R)..............1862 Riverside, Columbus, Oh. 43212
Syphax, Charles S.......4000 W. Davison, Detroit 48238
Szappanyos, G. G. (A).....Hosp. Cantonal De Geneve., Geneve, Switzerland
Szilagyi, D. Emerick...Henry Ford Hosp., Detroit 48202
Szokolay, Joseph P.....Henry Ford Hosp., Detroit 48202
Taber, Rodman E.......Henry Ford Hosp., Detroit 48202
Tactac, Albert J.........15240 Merriman, Livonia 48154
Tadian, Joella G.......23100 Cherryhill, Dearborn 48124
Tagett, John P...25750 W. Outer Dr., Lincoln Park 48146
Talbot, Frank G..............1365 Cass, Detroit 48226
Tallant, Edward J........18041 Greenfield, Detroit 48235
Talley, Robt. W.........Henry Ford Hosp., Detroit 48202
Talmers, Fredk. N.........V.A. Hospital, Dearborn 48121
Tamblyn, E. J. (L).....737 Marlborough, Detroit 48215
Tan, Liong G...............888 Chalmers, Detroit 48215
Tanay, Emanuel.........861 Fisher Bldg., Detroit 48202
Tandoc, Jose S...........Ford Motor Co., P.O. Box 570, Warren 48090
Tanner, Natalia M...8401 Woodward Ave., Detroit 48202
Tapert, Julius C. (A) 120 Mackinac, Harsens Island 48028
Tarpinian, Harry...10955 Farmington Rd., Livonia 48150
Tasker, Helen E.......76 W. Adams Ave., Detroit 48226
Tassie, Ralph N. (L)..15000 Gratiot Ave., Detroit 48205
Tatelis, Gabriel A...21811 Kelly Road, East Detroit 48021
Tatelman, Maurice..6767 W. Outer Drive, Detroit 48235
Taurence, Wm. H.....1860 Ford Ave., Wyandotte 48192
Tavlan, Cemalettin....Annapolis Hospital, Wayne 48184
Taylor, Amos, III...........301 E. Kirby, Detroit 48202
Taylor, Junius L.....1566 W. Grand Blvd., Detroit 48208
Taylor, Miles.......550 Estld. Prof. Bldg., Detroit 48236
Taylor, Nelson M...215 Dean Lane, Grosse Pte. Park 48236
Taylor, Richard A.......28 W. Adams St., Detroit 48226
Taylor, Ward M.....2201 E. Jefferson Ave., Detroit 48207
Taylor, Wm. V.........17200 E. Warren, Detroit 48224
Tazzioli, Henry A.......21970 Moross Rd., Detroit 48236
Tear, Malcolm J. J...862 W. McNichols Rd., Detroit 48203
Teitelbaum, Myer....18510 Meyers Road, Detroit 48235
Tellez, Henry (A)..........Wayne St. Univ. Hosp. Tng., Detroit 48207
Telmos, Allen J...16401 Grand River Ave., Detroit 48227
Tenaglia, Thos. A......3180 Fort St., Lincoln Park 48146
Teves, Manuel L.............13020 Mack, Detroit 48215
Texter, Elmer C. (L) 915 Harcourt Rd., Grosse Pte. 48230
Theodoulou, Anna M...............Grace Hosp., N. W., 18700 Meyers Rd., Detroit 48235
Theodoulou, Glaucos........1800 Tuxedo, Detroit 48206
Thomas, Leon D.........17320 Livernois, Detroit 48221
Thomas, L. Murray............801 Dav. Whitney Bldg., Detroit 48226
Thompson, Arthur L.........12632 Dexter, Detroit 48238
Thompson, Hugh O.....6014 W. Fort St., Detroit 48209
Thompson, Wm. A. (R)....12632 Dexter, Detroit 48238
Thomson, Danl. C.....2934 Biddle Ave., Wyandotte 48192
Thornton, Jerry A..........525 Visger Rd., Ecorse 48229
Thosteson, G. C...1139 Dav. Whitney Bldg., Detroit 48226
Thumann, Robt. C...................20045 Mack Ave., Grosse Pte. Woods 48236
Thumin, Sadie............15306 Joy Rd., Detroit 48228
Timma, Richard J............17220 W. Eight Mile Rd., Southfield 48075
Ting, Sik Woo.........Oakwood Hosp., Dearborn 48124
Ting, Yeeh Ming....29555 Bristol Rd., Birmingham 48010
Toal, Robert E........20953 Grand River, Detroit 48219
Tobar, Rodrigo R.....21110 Winchester, Southfield 48075
Todoroff, Theodore G...22146 Ford Rd., Dearborn 48128
Tolbert, Jesse C.....8401 Woodward Ave., Detroit 48202
Tolbert, Vassal G.............3461 W. C. Chrysler Exp., Detroit 48201
Torres, Estelle P.........3985 Caniff, Hamtramck, 48212
Torres, Raul M., Jr.....3985 Caniff St., Hamtramck 48212
Tourkow, Lawrence P.............3290 Sherbourne Rd., Detroit 48221
Townsend, Frank M. Jr., (L)...........1055 Trumbull, Detroit 48216
Tracey, John M.......15317 W. McNichols, Detroit 48235
Tracy, Edward G.........3411 Evaline St., Detroit 48212
Treisman, E. J...15105 W. Seven Mile Rd., Detroit 48235
Tremain, Harold L.........15475 Ashton, Detroit 48223
Triska, Franz K.....18750 Woodward Ave., Detroit 48203
Troester, Geo. A..............81 E. Kirby, Detroit 48202
Trotsky, Martin B........7411 Third Ave., Detroit 48202
Truba, Paul K.......22770 Kelly Rd., East Detroit 48021
Trudeau, John M...........14200 Puritan, Detroit 48221
Trudgen, Paul E.......1224 Beechmont, Dearborn 48124
Trunsky, Ronald E.........Sinai Hospital, Detroit 48235
Trupiano, Samuel..420 Eastland Prof. Bldg., Detroit 48236
Trythall, S. W.............Box 33, Orchard Lake 48033
Tsangalias, S. S....63 Kercheval, Grosse Pte. Farms 48236
Tseng, George T. C...................5948 Cambourne, Dearborn Hts. 48127
Tukel, Floyd S............1922 Monroe, Dearborn 48124
Tulloch, John A...................17800 E. 8 Mile Rd., Harper Woods 48236

Tulloch, John C. . .1040 Dav. Whitney Bldg., Detroit 48226
Tumbokon, R. T. . . . . .VA Hospital, Allen Park 48101
Tupper, Roy D. (L). .15101 W. 7 Mile Rd., Detroit 48219
Turcotte, Vincent J. (A). . . . . .545 Lakeland Ave. Grosse Pointe 48230
Turkel, Henry. . . .8000 W. Seven Mile Rd., Detroit 48221
Turla, Benjamin S. . . . . . . .Grace Hospital, Detroit 48201
Turnbull, Jack V. . .22340 Michigan Ave., Dearborn 48124
Turner, Edward T. . . . . . . .5050 Joy Road, Detroit 48204
Turner, Rachel E. . . . . .895 W. Oakridge, Ferndale 48220
Turner, Robert R. . . . .2841 Monroe Blvd., Dearborn 48124
Tworek, Taisja Z. . . . . .2 Woodside Park Blvd., Pleasant Ridge 48069
Uddyback, Odie T. . .8401 Woodward Ave., Detroit 48202
Ujda, Chester J. . . . . . . .32302 Woodbrook, Wayne 48184
Ulmer, Arthur A. . .79 Greenbriar, Grosse Pte. Shores 48236
Ulrich, John L. . . . . . .18550 W. Outer Dr., Dearborn 48128
Ulrich, Willis H. . .22365 Grand River Ave., Detroit 48219
Underberg, John. . . . . .Harper Hospital, Detroit 48201
Unkefer, Wm. T. . . . .17401 Greenfield Rd., Detroit 48235
Usndek, Harold E. . . . . .18485 Mack Ave., Detroit 48236
Vachher, P. S. . . . . .32300 Schoolcraft, Livonia 48150
Vaitas, Otonas. . . . .10531 Farmington Rd., Livonia 48150
Vaitkevicius, V. . . . . .4160 John R, Detroit 48201
Valdesuso, R. I. . . . . .14763 Rossini Dr., Detroit 48205
Valdez, Jose V. . . . . .5450 Fort St., Trenton 48183
Valenzuela, E. Valdes. .28382 Harwich, Farmington 48024
Van Arsdale, Wm. L. (A). . . . . . . .1000 Chung Cheng Rd., Taipei, Taiwan
Van Becelaere, L. A. . . . . .15830 Fort, Southgate 48192
Vanden Berg, H. J., Jr. . . . . .1553 Woodward Ave., Detroit 48226
Van Eck, James E. . . . . .11540 Morang Dr., Detroit 48224
Van Hoek, Donald E. . . . . .20323 Mack, Grosse Pte. Woods 48236
Van Raaphorst, L. F. . . . . . . .861 Monroe, Dearborn 48214
Van Riper, Steven L. . . . . .1490 Iroquois, Detroit 48214
Van Slyck, E. J. . . . . . . .Henry Ford Hosp., Detroit 48202
Vanvalzah, Henry J. . . . . .Ford Mtr. Co., Miller Rd., Dearborn 48120
Vardon, Edward M. (L). . . . . .12897 Woodward Ave., Highland Park 48203
Vartanian, Hratch. . . . . .6246 Chase Rd., Dearborn 48126
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Vaughn, Clarence B. . . . . . . .Grace Hospital, Detroit 48201
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Vera, Ramon W. . .15901 W. 9 Mile Rd., Southfield 48075
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Villani, Patrick A. . . . .20914 Kelly Rd., East Detroit 48021
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Viscomi, Geo. J. . . . . .23422 Ford Rd., Dearborn 48128
Visscher, Donald W. . .12922 W. Warren, Dearborn 48126
Vogel, Lloyd (A). . . . . .Ophthalmology Dept., Detroit General Hosp., Detroit 48226
Vokes, Milton D. (L). .10182 Gratiot Ave., Detroit 48213
Von Brauchitsch, H. K. . . . . .Henry Ford Hospital, Detroit 48202
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Vonder Heide, Elmore C. (A). . . . . . . .17190 Strathmoor, Detroit 48235
Vonglahn, Noel A. . . . . . .19075 Middlebelt, Livonia 48152
Vorwald, Arthur J. . . . . .1401 Rivard St., Detroit 48207
Vossler, Albert E. (L). . . . . . . .1144 Dav. Whitney Bldg., Detroit 48226
Voudoukis, I. J. . . . . .3800 Woodward Ave., Detroit 48201
Wagenberg, Harold R. . . . . .20600 Bradford Ct., Southfield 48075
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Wagner, John R. . . . . .474 Fisher Bldg., Detroit 48202
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Wainger, Max J. . . . . .15105 W. 7 Mile Rd., Detroit 48235
Wainstock, Michael A. . . . . .621 David Whitney Bl., Detroit 48226
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Walker, Frank B., II. . . . . .1206 Balfour Rd., Grosse Pte. Park 48230
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Wang, Chun Heng H. . .25500 Edgemont, Southfield 48075
Wang, Joy Ya Hsiang. . . . . .2020 Middlebelt, Garden City 48135
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Waszak, Chas. J. .26111 Woodward, Huntington Woods 48070
Waters, William L. . . . . . .Burns Clinic, 560 W. Mitchell, Petoskey 49770
Watling, Robert L. . .15761 Andover Dr., Dearborn 48120
Watson, Harwood G. . . . . .935 S. Military Ave., Dearborn 48124
Watson, James E., Jr. . . .18524 Grand River, Detroit 48223
Watts, Fredk. B. . . . . .16321 Mack Ave., Detroit 48224
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Watts, Jos. C. . . . . .15901 W. 9 Mile Rd., Southfield 48075
Wayne, Morris A. . . . .15930 Livernois Ave., Detroit 48221
Weaver, Clarence E. (R). . . . . .1260 S.E. Fourth Ct., Deerfield Beach, Fl. 33441
Weaver, Delmar F. . . . . .1100 Bishop, Detroit 48230
Weber, Karl W. . . . .18101 E. Warren Ave., Detroit 48224
Webster, Jeremy D. . . . . . .20045 Mack, Grosse Pte. 48236
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Weed, Milton R. . . . . .1059 Berkshire Rd., Grosse Pte. Park 48236
Wegryn, Richard S. . . . . .Detroit Memorial Hosp., Detroit 48226
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Weiksnar, John F. . . . . .1800 Tuxedo, Detroit 48206
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Weisenthal, Irvin I. . .5764 Woodward Ave., Detroit 48202
Weiss, Casimir P. . . . . .10036 Jos. Campau, Detroit 48212
Weiss, Irving R. . . . . .25 Pearl St., Galesburg 49053
Weissman, Fredrick. . . . . .20905 Greenfield Rd., Southfield 48075
Welch, John H. . . . .18550 W. Outer Dr., Dearborn 48128
Welhaf, William R. . . . .22101 Moross Rd., Detroit 48236
Wells, Herschel J. . . .Wayne Co. Gen. Hosp., Eloise 48132
Wells, Martha L. (A). .584 Pilgrim Rd., Birmingham 48009
Welsh, Gary J. O. . . . . .3535 W. 13 Mile Rd., Royal Oak 48072
Weltman, Carl G. (A). . . . . .R.R. 2, Snead Island, Palmetto, Fl. 33561

Wenokur, Milford E...26070 Meadow Dr., Franklin 48025
Wenzel, Jacob F.........18555 E. Warren, Detroit 48236
Werle, Peter P...62 Greenbriar, Grosse Pte. Shores 48236
Wertz, Wm. J.........2405 W. McNichols, Detroit 48221
West, Howard G...........12739 Puritan, Detroit 48227
West, Howard J..........Harper Hospital, Detroit 48221
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Weston, Horace L...15901 W. Nine Mile, Southfield 48075
Weyher, Russell F. (L)...........5383 Oakman Blvd., Detroit 48204
Whalen, Neil J. (L)..1553 Woodward Ave., Detroit 48226
Whaley, Robert L.......3150 Second Ave., Detroit 48201
Wharton, Thos. V.........1809 Oak St., Wyandotte 48192
Wheatley, Charles E. (A)..4407 Roemer, Dearborn 48126
Wheeler, Stewart C...........18901 W. McNichols Rd., Detroit 48219
Whelan, Jos. L.......28 W. Adams Ave., Detroit 48226
White, Donald H.......20685 Meridian, Grosse Ile 48138
White, Jacob E...........3413 McDougall, Detroit 48207
White, Milton W.......1439 E. Outer Dr., Detroit 48234
White, Prosper D......58 W. Adams Ave., Detroit 48226
White, Theodore M.....7341 W. Warren, Detroit 48210
Whitehead, Leston S.............1553 Woodward Ave., Detroit 48226
Whitehead, Walter K...........17800 E. Eight Mile Rd., Detroit 48236
Whitehouse, Fred W...2799 W. Grand Blvd., Detroit 48202
Whiteley, Robt. K.............608 Estlnd. Cen. Prof. Bl., Detroit 48236
Whitelock, Edward H....1809 Oak St., Wyandotte 48192
Whitman, James E. 3920 E. Eight Mile Rd., Detroit 48234
Whittaker, Alfred H. (L)............3 Elmsleigh Lane, Grosse Pointe 48230
Whitten, James I. (M)..............50 Minden Circle, Colorado Springs, Co. 80906
Wiechowski, Henry E.............10345 Joseph Campau, Detroit 48212
Wiener, Israel....13011 W. McNichols Rd., Detroit 48235
Wiener, Morton J.........150 Livernois, Ferndale 48220
Wietersen, Fred K......18700 Meyers Rd., Detroit 48235
Wikiera, Edward S......15120 Michigan, Dearborn 48126
Wilcox, Leslie F......................505 Middlesex Rd., Grosse Pte. Park 48236
Wilhelm, Rudolf E...751 S. Military Rd., Dearborn 48124
Wilhelm, Seymour K...13011 W. McNichols, Detroit 48235
Wilkins, Robert B. (A)..........Detroit General Hosp., Detroit 48226
Wilkinson, Arthur P. (R)..........4840 Willow Lane, Orchard Lake 48033
Williams, Delford G.........5050 Joy Rd., Detroit 48204
Williams, Earl R...........4407 Roemer, Dearborn 48126
Williams, Eugene W.....6246 Chase Rd., Dearborn 48126
Williams, John H........18633 Mack Ave., Detroit 48236
Williams, Joshua S.......5050 Joy Road, Detroit 48204
Williamson, W. A.....2585 W. Grand Blvd., Detroit 48208
Willis, Robt. L., Jr...........6506 Covington Rd., #316, Ft. Wayne, Ind. 46804
Willoughby, Wm. A......974 Fisher Bldg., Detroit 48202
Wilner, Freeman M...........15001 W. Eight Mile Rd., Detroit 48235
Wilner, Irvin A.....17701 McNichols Rd., Detroit 48235
Wilson, Andrew G.............19203 Grand River Ave., Detroit 48223
Wilson, Francis M.........15439 Harper, Detroit 48224
Wilson, Gerald A. (L)..19203 Grand River, Detroit 48223
Wilson, Gerald S.....3011 W. Grand Blvd., Detroit 48202
Wilson, Ian D.............Burns Clinic Medical Center, Petoskey 49770
Wilson, Merton C......15439 Harper Ave., Detroit 48224
Wilson, Paul H.......901 W. Grand Blvd., Detroit 48208
Wilson, Robert F...Detroit Receiving Hosp., Detroit 48226
Wimmer, Helmut..........1337 Joliet Pl., Detroit 48207
Winkler, Helen H.....14411 E. Jefferson, Detroit 48215
Winnick, Lawrence....13340 W. 7 Mi. Rd., Detroit 48235
Winton, Geo. J.........1150 Griswold St., Detroit 48226
Wise, Robt. K....17640 W. 12 Mile Rd., Southfield 48075
Wishropp, Edward A. (L) 20250 Mack, Grosse Pte. 48236
Withey, Grant J.............7430 Second, Detroit 48202
Wittenberg, Arthur..7101 W. Chicago Blvd., Detroit 48204
Wittenberg, D. H.......1535 E. State Fair, Detroit 48203
Wittenberg, Samson S....18718 Woodward, Detroit 48203
Wittenberg, Sydney S...4400 Livernois Ave., Detroit 48210
Witter, Jos. A...134 W. Univ. Dr., #304, Rochester 48063
Witus, Morris (A)..1500 Bay Rd., Miami Beach, Fl. 33139
Wlodarczyk, A. J...........1348 Joliet Pl., Detroit 48207
Wolfe, John N...........432 E. Hancock, Detroit 48201
Wolfe, Max O. (L)..7 260 Gen. Mtrs. Bldg., Detroit 48202
Wolfram, Bonnie R...620 New Center Bldg., Detroit 48202
Wolfson, Wm. Q...........3000 Seminole, Detroit 48214
Wolodzko, Joseph....32900 Five Mile Rd., Livonia 48154
Wolter, James G...Mt. Carmel Mercy Hosp., Detroit 48235
Womack, Melisande.........1800 Tuxedo, Detroit 48206
Wood, Alfred L.......23100 Cherry Hill, Dearborn 48124
Wood, Douglas J.........2860 Clark Ave., Detroit 48210
Wood, Kenneth A.........3919 John R St., Detroit 48201
Wood, Wilford C. (L)..3011 W. Gr. Blvd., Detroit 48202
Woodbury, Ralph F......21223 Mack, Grosse Pte. 48236
Woodley, Bernard J........3700 West Rd., Trenton 48183
Woodring, Albert J. (A)..Harper Hospital, Detroit 48201
Woods, Joseph J....2022 Washtenaw Rd., Ypsilanti 48197
Woolfenden, Jos. B.....1547 Blairmoor, Grosse Pte. 48236
Worrell, Calier H...20250 Mack, Grosse Pte. Woods 48236
Worzniak, Jos. J.....2312 Biddle Ave., Wyandotte 48192
Wreggit, Winston R.................17 Colorado Ave., Highland Park 48203
Wright, Charles H.........50 Westminster, Detroit 48202
Wu, Clyde Ying Chau..........825 Dav. Whitney Bldg., Detroit 48226
Wyatt, Rudolph A........2785 S. Fort St., Detroit 48217
Wybranowski, Jan......17644 W. Warren, Detroit 48228
Wylie, John H.........Henry Ford Hosp., Detroit 48202
Wylin, Robert...........Harper Hospital, Detroit 48201
Wysocki, Raymond L......2536 Rutledge, Trenton 48183
Yapchai, Rodolfo.1846 Dav. Whitney Bldg., Detroit 48226
Yarjanian, Ara........3815 Pelham Rd., Dearborn 48124
Yarrows, Morton I.......455 Medbury St., Detroit 48202
Yates, Arthur J. W...................16355 E. Jefferson, Grosse Pte. Park 48236
Yesayian, H. G. (L)......609 Kales Bldg., Detroit 48226
Yoder, Robt. R.........20189 Whipple, Northville 48167
Yott, Wm. J...........854 Lakeshore Rd., Detroit 48236
Young, David J.....19820 Plymouth Road, Detroit 48228
Young, Donald A.............14807 W. McNichols Rd., Detroit 48235
Young, Donald C. (R)...........43875 Nine Mile Rd., Northville 48167
Young, Frank A.............344 Glendale, Detroit 48203
Young, Irving I.....32280 Shrewsbury, Farmington 48024
Young, Richard D.......31500 Schoolcraft, Livonia 48150
Young, Viola M. (L).....10 Peterboro St., Detroit 48201
Youngstrom, Clarence S...8004 Lochdale, Dearborn 48127
Yudashkin, Ernest G.............Northville State Hosp., Northville 48167
Zabinski, Edward J.....585 Ballantyne Rd., Detroit 48234
Zack, Burton J...........19467 Livernois, Detroit 48221
Zadeh, A. T.......27489 W. Six Mile Rd., Livonia 48152
Zako, Louis R..........7720 Allen Rd., Allen Park 48101
Zaleski, Edward J........4520 Firestone, Dearborn 48126
Zane, Alan Irving.........7411 Third Ave., Detroit 48202
Zara, Sabah E...............15830 Fort, Southgate 48192
Zavell, Paul M....92 Moran Rd., Grosse Pte. Farms 48236
Zawacki, Sigmund G.....22146 Ford Rd., Dearborn 48128
Zbikowski, Jos......31500 Schoolcraft Rd., Livonia 48150
Zbikowski, Z. T.....31500 Schoolcraft Rd., Livonia 48150
Zbudowski, Myron R...........10040 Jos. Campau Ave., Detroit 48212
Zelenock, Michael N........15830 Fort, Southgate 48192
Zemaitis, Petras.........33000 Palmer Rd., Wayne 48184
Zemens, Jos. L.......11420 E. 9 Mile Rd., Warren 48089
Zevallos, Carlos........5800 W. Fort St., Detroit 48209
Zimberg, Leslie L. (A)..24386 Rensselaer, Oak Park 48237
Zinn, Geo. H. (L)...1553 Woodward Ave., Detroit 48226
Zirkin, Richard M...3105 Carpenter Avenue, Detroit 48212
Zobl, Eldred......15901 W. 9 Mile Rd., Southfield 48075
Zolliker, Margaret Z.......289 Moross, Grosse Pte. 48236
Zubroff, L. S............760 Fisher Bldg., Detroit 48202
Zuelzer, Wolf W.......5224 St .Antoine St., Detroit 48202
Zukowski, Henry J.......72 N. Deeplands, Detroit 48236
Zukowski, Sigmund A.....6626 Van Dyke, Detroit 48213
Zwirkoski, T. S...25000 W. 10 Mile Rd., Southfield 48075
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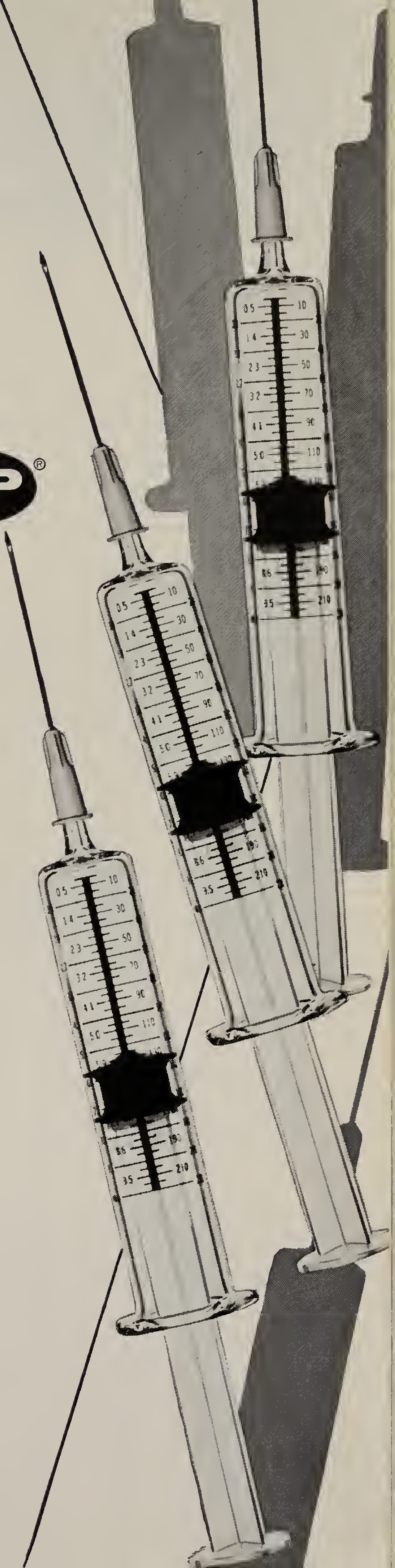

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MICHIGAN MEDICINE

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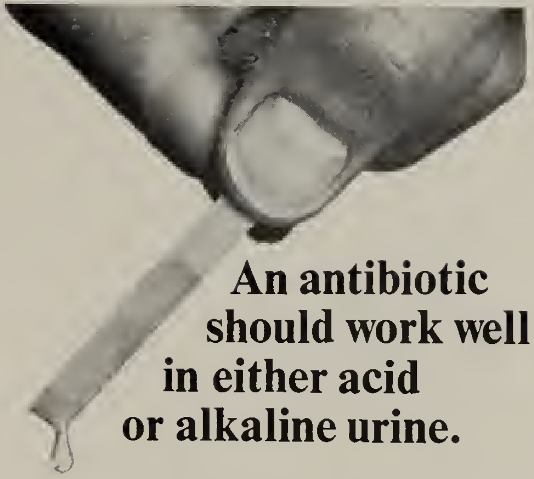

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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BY JAMES J. LIGHTBODY, M.D.

MSMS PRESIDENT'S MESSAGE

For many years, we have had two political parties — they have been the Republican and the "Labor" Party. Labor unions have dominated the Democratic Party for too many years. The words "Liberal" and "Conservative" have been kicked around so much that we are more confused than usual about their real meaning.

Why should most of the large labor unions in this country persistently side-in with the Democrat Party and try to impress their large membership to vote Democratic in all important elections? It is obvious that the so-called "rank and file" members of unions have very little, if anything, to do with the political decisions and aspirations of their leaders. All that the union members are supposed to do is to pay their dues which are deducted from their regular paychecks and, with the assistance of the "checkoff" system, are automatically sent to the union headquarters.

The American Medical Association is not a political machine favoring either party and we can imagine what reaction the physicians of this country would have if the A.M.A. told them how to vote. It is generally agreed that the majority of physicians favor the more conservative approach to socio-economic problems of the country.

During the recent elections there was very little difference in the basic philosophy of the two main political parties as election time approached. Public opinion and expediency have much to do with the changing programs of both parties.

The recent election has proven that the Democrat Party, which traditionally was a predominant liberal philosophy, has changed its attitude because there seems to be a decreasing amount of federal funds available to pay for all of the programs sponsored by the Democratic administration. On the other hand — the Republican Party developed a semi-liberal attitude concerning some present programs and even suggested a few new ones to assist those groups of people who were economically, educationally and environmentally in the sub-standard classes.

We may eventually end up with a ten or fifteen party system that will add a little more confusion to the solitary confinement of our curtained voting booth. Anyway — ten or fifteen parties is too many — even during the Holiday Season.

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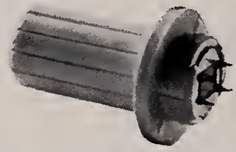

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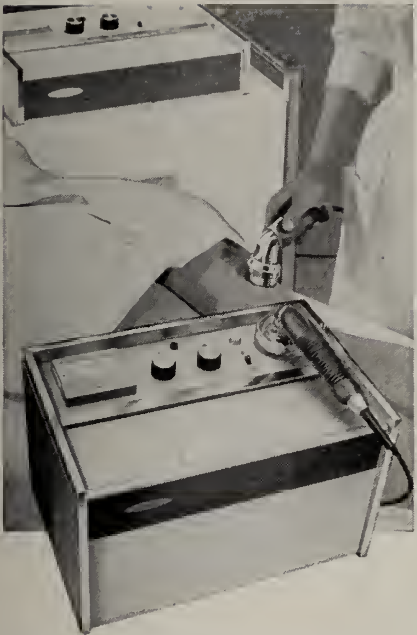

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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VIEWPOINTS

Welcome to Associate Scientific Editors

The MSMS Publication Committee is pleased to announce the formation of a board of Associate Scientific Editors. The names and addresses of the Associate Editors are listed in this and succeeding issues.

The Publication Committee has attempted to obtain Associate Editors representing geographic areas, speciality representation, medical school representation and clinical practice.

We are very happy to have such an excellent group representing *Michigan Medicine.*

Obesity Challenge

BY BROOKER L. MASTERS, M.D., CHAIRMAN
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As a physician are you doing the best job possible in handling obesity patients and in assuming leadership in the even broader field of nutrition?

"Middle-age obesity is said to be the major illness of our land today," writes C. F. Enloe, Jr., MD, in a recent issue of *Nutrition Today.*

Doctor Enloe then goes on to contend "that the practicing physicians' role in trying to get a firm grip on the obesity problem is less than enviable."

It seems to this observer that MSMS members and our Michigan research institutions do not focus proper attention on this common health problem and give it the attention it deserves. While we hesitate, the quacks and charlatans have moved into this field.

Doctor Enloe, in his article, "Are We Well Fed? Who Knows?," suggests several other related areas of concern. He suggests anything that can be done to improve the nutrition of the elderly is not only a moral obligation but economically wise.

We are not only concerned about nutrition of the elderly but also about the eating habits of children and young people. Often children and young people (who can afford good balanced meals) choose poor foods for their school lunch. We know that some children of the affluent often go to school with no breakfast or with a poor one. The nutritional status of our young people is so important; girls especially because they are becoming pregnant and giving birth at younger ages than a decade ago.

Physicians can and must work with dietitians and nutritionists to apply research to find out the facts; and then use our vast intellectual and physical resources to solve the nutritional problems that face too many children and adults, the elderly and poor in our communities, in Michigan, and the nation.

There Are No Short-cuts

(Editor's Note: This article appeared in a recent issue of the Genesee County Medical Society Bulletin; and was written by E. Marshall Goldberg, M.D., an associate editor.)

"It has been reliably estimated that only since the second decade of the twentieth century could a given patient consulting a given doctor reasonably hope to benefit from the encounter" . . . How things have changed!

The country doctor with his bag chock full of nostrums — most of which did little good, though, on the other hand, little harm — is a fond remembrance by many of us whose first interest in a career in medicine was kindled by the welcome sight of the venerable gentleman. He cured rarely, comforted always.

Nowadays, much more is expected. We have entered the era of a knowledge explosion. The turnover rate for new medical knowledge, 25 years in 1950, has now shrunk to five years — which, in effect, means that if any of us stopped reading and absorbing the contents of at least four medical journals a month for a five-year stretch, we would be a prime candidate for another tour of medical school.

WHY? THE PRINCIPAL reason, in my opinion, is that there are so few **totally incurable diseases anymore.** Each passing day in some medical journal published somewhere on this globe, a new mode of therapy may appear that removes one more disease process from the "certain death" category.

It is the physician's responsibility to keep up with these developments — to read *The New England Journal* as well as the *Wall Street Journal*

— and to assure such potential benefit reaches his patient sooner rather than later. It should not be inferred from this reference that only patients with rare diseases merit such diligence. One of the leading causes of hospital deaths is pulmonary emboli. New diagnostic techniques, such as lung scanning, have recently become available to permit early detection of this condition.

YET, HOW MANY physicians have made a concerted effort to familiarize themselves with both the subtle manifestations of pulmonary embolization and the usefulness and limitations of lung scans?

Multiple Myeloma, once a relentless process, has now yielded, in part, to combined therapy with such agents as cytoxan, sacrolysin, fluorides, androgens and cortisone. It remains a fatal disease, yet not totally incurable in the sense that several, reasonably comfortable years can be added to the patient's life by judicious management with these modalities.

Many state medical societies — most notably, Oregon's — have publicly recognized that a physician whose knowledge is out of date can be as much a hazard as a healer. His diagnostic acumen is the first to be tested by a patient suffering the ill-defined, early symptoms of a potentially serious disease.

IT IS NOT ENOUGH FOR him to know where he can refer the patient for "specialized" care. He must first make a tentative diagnosis; he must be truly skilled in the routine, often tedious, but indispensable art of doing a first-rate history and physical.

There are no short-cuts to this ritual; it is still at least 80 percent of the practice of good medicine. For the remainder, it is my opinion that the busy practitioner should avail himself more of the teaching program in his hospital; bend the program to fill his needs, correct the weak spots, as well as those of the fledgling house officer.

If he and a few of his colleagues feel they need a little brushing up in the latest techniques for, say, working up a patient with hypertension, he should make his feelings known to the educational director or the chief of the section rather than wait for a yearly conference on the subject.

He should be an ACTIVE rather than a passive — or worse, ABSENT — recipient of what his hospital has to offer him as a life-long student of medicine. It is unrealistic to expect to be able to catch up on all the medical advances that have been made in a year by attending a single refresher course. New knowledge, like good scotch, should be taken in small sips.

E. Marshall Goldberg, M.D.

Impotence

(Editor's Note: The following message appeared in a recent issue of the Oakland County Medical Society Bulletin.)

Once or twice a week some member of the Oakland County Medical Society stops me and asks "When is the county medical society going to ____________________?" The subjects in question run the gamut: community health, hospital politics, Medicare, Blue Cross-Blue Shield, Vietnam, etc. The answer is simple enough. Our county medical society is not an influential or potent organization and it is high time we stop having any illusions about our own importance as a political force.

Too many of our members contribute nothing to their county medical society. I can accept poor attendance at our monthly meetings as a fact of life but I cannot understand the lack of attendance at committee meetings. A year ago, I made an attempt to appoint people, including many new members, who expressed a willingness to work for the society as members of committees. Inexplicably most of our important committees are struggling along, their efforts hamstrung by less than 25 per cent participation by their members. As a case in point, several months ago our local schools asked for assistance in the area of student drug addiction. The responsible OCMS Committee met with only two of nine members present. No action was taken and the schools went elsewhere for help.

The cure for such impotence in any organization is the active and enthusiastic participation by its members.

Edwin J. Westfall, M.D.
President,
Oakland County
Medical Society

The Old Maid Still at the Keyhole

(Editor's Note: The following editorial by John S. Chapp Chaffee is reprinted from the May, 1968 issue of PENNSYLVANIA MEDICINE, published by the Pennsylvania Medical Society.)

Many years ago the renowned John B. Deaver received a phone call from one of his many referring G.P.'s. "John," said the referring doctor, "I've got an old spinster out here whom I believe has a gallstone colic. You should operate her, but they won't take my word for it. Now, if you were to come out here in consultation, you might persuade her to come to the hospital and get the operation over with."

The great Deaver went to the home accompanied by the doctor and with characteristic dignity examined the old maid. Then he asked to be excused so that he and the family doctor could discuss the case. They retired to the drawing room, closed the door and sat down. The family doctor handed Doctor Deaver a cigarette and they both lit up. After a pause, Doctor Deaver said, "Did you ever see such a homely old maid in your life?" To which the referring doctor replied, "If you think she is homely, wait until you see her sister."

At that moment, the door flew open. The enraged sister, who had been listening thru the keyhole, summarily ordered them both out of the house.

Perhaps physicians can hazard a lesson from this Philadelphia story.

A complacent medical profession irritated by the perplexities of public service, is over-confident because it is in short supply. The public, represented by the old maid, is observing us through the keyhole with a suspicious eye. It considers us a valued servant and tolerates great latitudes in our behavior. But if we are indiscreet in our professional obligations or disrespectful to our master, the public, we may awake to an enraged old lady who will toss us out or curtail our activities.

The old lady may be ever so homely, even unreasonable and we may not like her politics. Nevertheless, while being firm with her, we must patiently educate her and render her intelligent service. We must not insult her, for she is our master and we are her servants.

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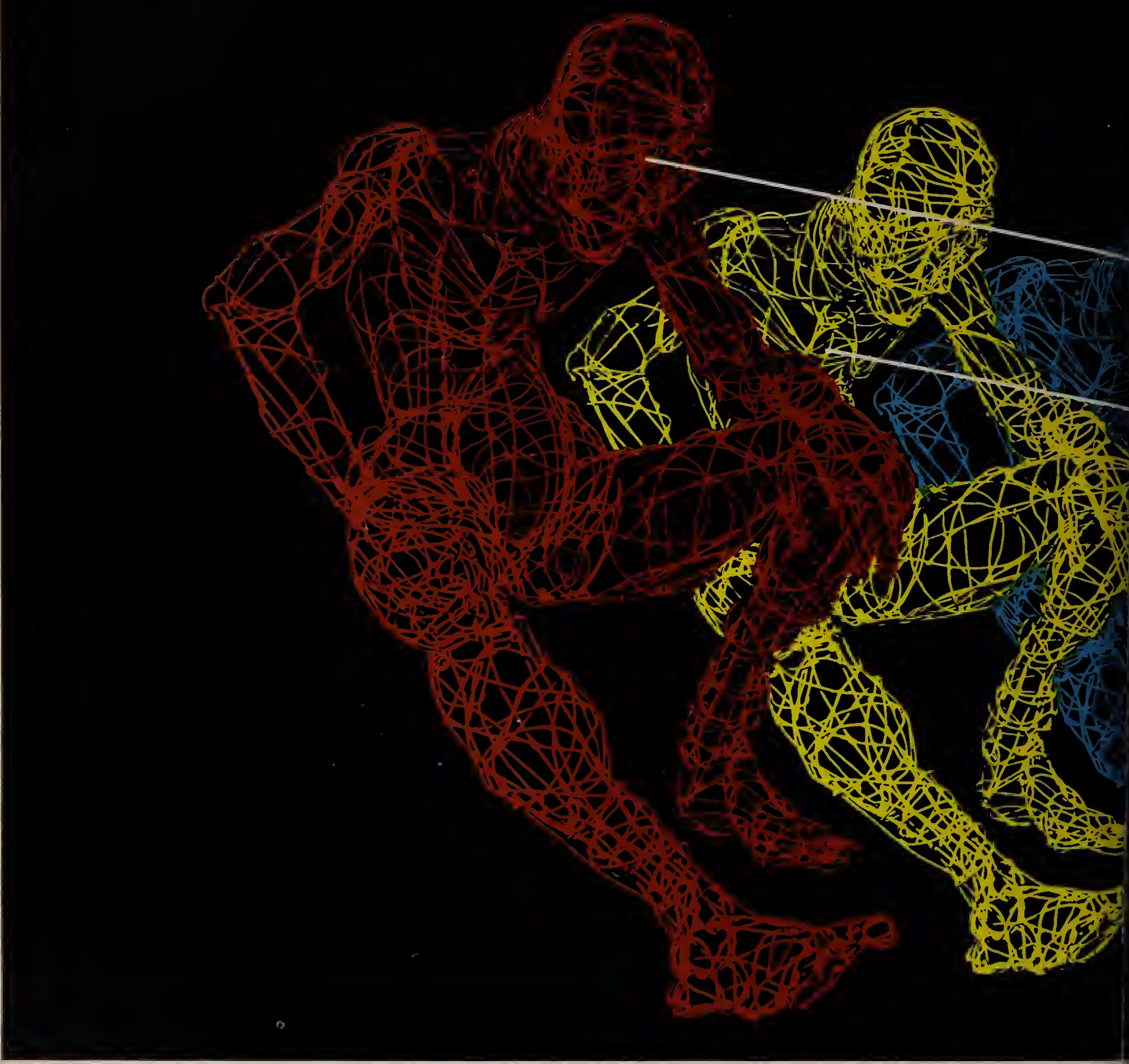
PARKE-DAVIS 015R67

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	
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Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appro
investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without ad
vitamin B_{12} therapy may result in hematologic remission bu
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concentrate with intrinsic factor, Lilly]) usually prevent, h
improve the neurological changes.

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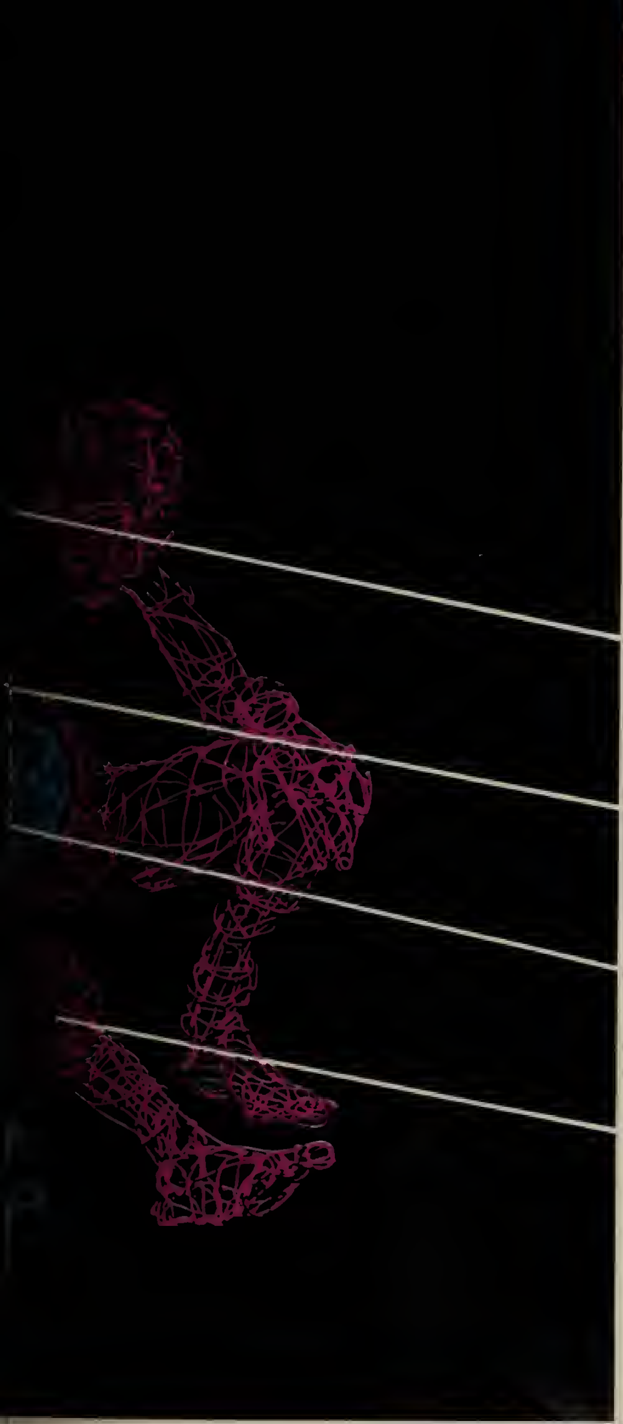
may develop in some cases of pernicious anemia to the po
tion of absorption of physiological doses of vitamin B_{12}. If
ance occurs, parenteral therapy, or oral therapy with so
massive doses of vitamin B_{12}, may be necessary. No singl
men fits all cases, and the status of the patient obser
follow-up is the final criterion for adequacy of therapy. P



You can treat combined deficiencies with

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Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

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se Reactions: In rare instances, iron in therapeutic doses ces gastro-intestinal reactions, such as diarrhea or consti- . Reducing the dose and administering it with meals will ize these effects.

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je: One Pulvule twice a day. (Two Pulvules daily produce a ard response in the average uncomplicated case of perni- anemia.)

Supplied: Pulvules Trinsicon® (hematinic concentrate with ic factor, Lilly), in bottles of 60 and 500. [032568]

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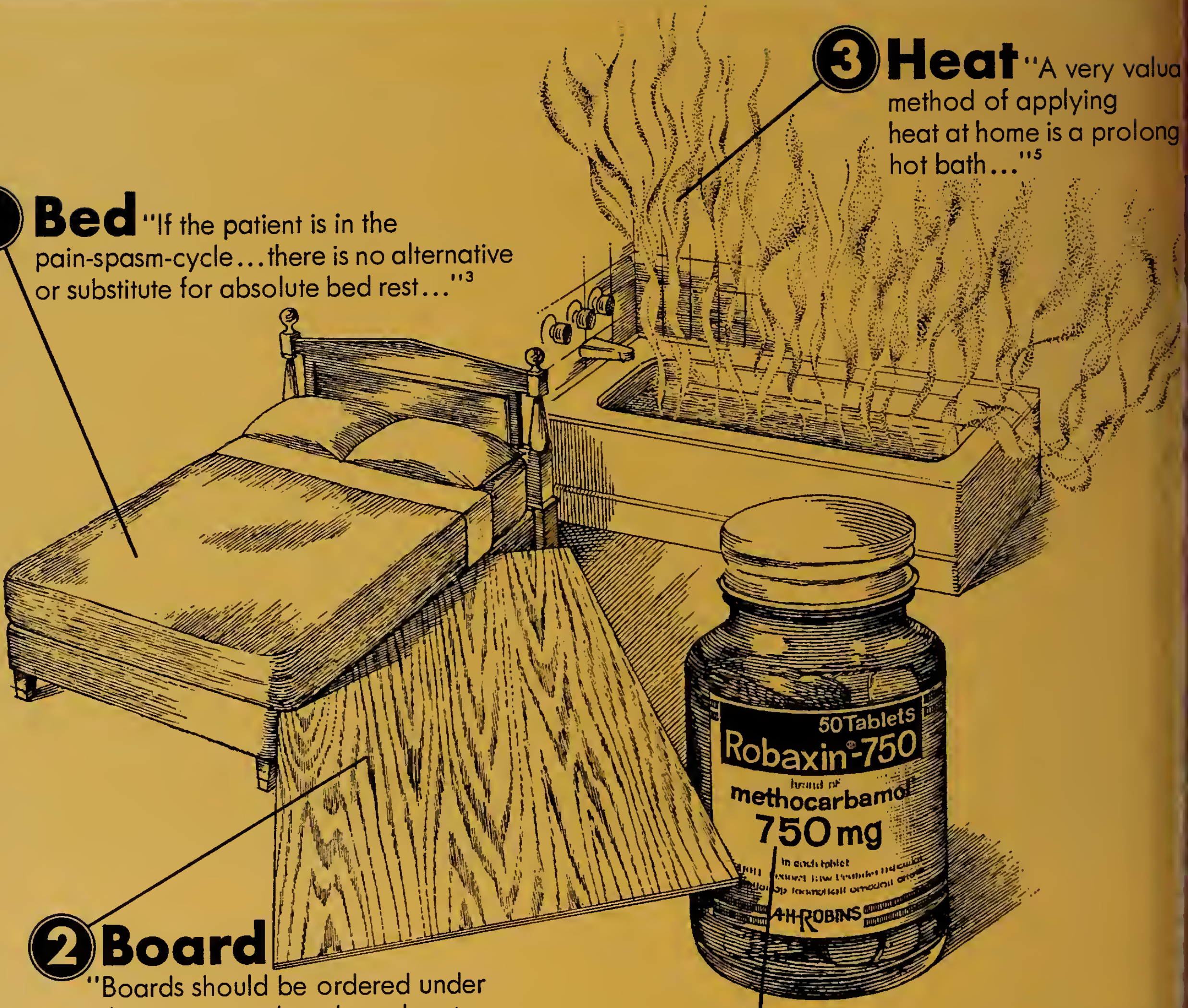
A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



①Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

②Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

③Heat "A very valua method of applying heat at home is a prolong hot bath..."[5]

④Robaxin®-750 (methocarbamol, 750 mg. capsul shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methoco bamol helps relieve spasm "...without interfering with norm tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.) **References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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the complex picture
moderate to severe anxiety...

ere is a [new] reason
: prescribing Mellaril
(Thioridazine HCl)

ectiveness in
xed anxiety-depression

; recognized for its usefulness in the
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aril is now also known to be effective
ıst mixed anxiety-depression.

n the symptoms of anxiety states are
:ult to sort out—even with the most careful
ing. The patient may manifest symptoms of
tion, restlessness, insomnia, somatic
›laints. But what of the depression that may
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ıg possibilities of success—when there is
ety alone or a mixture of anxiety
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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.
Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
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Vitamin B_1	7.5 mg
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Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

ROERIG Rx
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CHAS. PFIZER & CO., INC.
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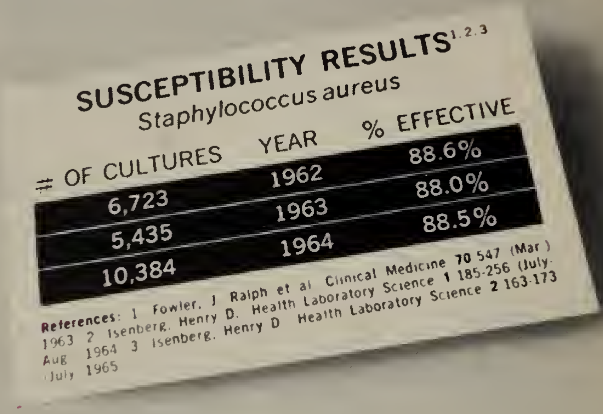
In vitro susceptibility results with TAO® (triacetyl-oleandomycin) in *Staphylococcus aureus* cultures, as shown in studies of antibiotics.



SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J Ralph et al Clinical Medicine 70 547 (Mar) 1963 2 Isenberg, Henry D. Health Laboratory Science 1 185-256 (July-Aug 1964 3 Isenberg, Henry D Health Laboratory Science 2 163-173 (July 1965

TAO® (triacetyl-oleandomycin)

is a macrolide antibiotic, for use only in the treatment of acute severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to other less toxic agents.

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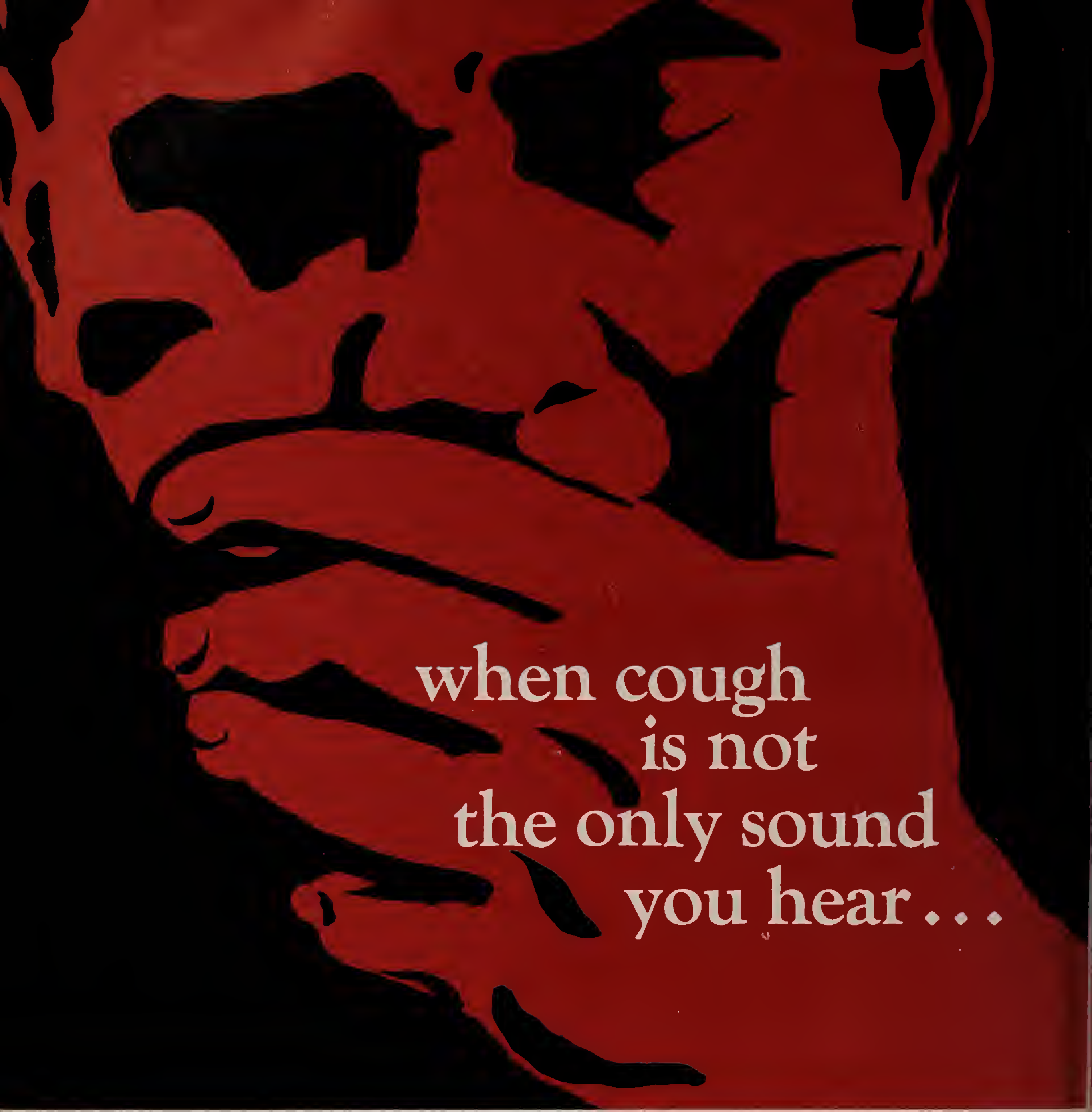
triacetyloleandomycin



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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
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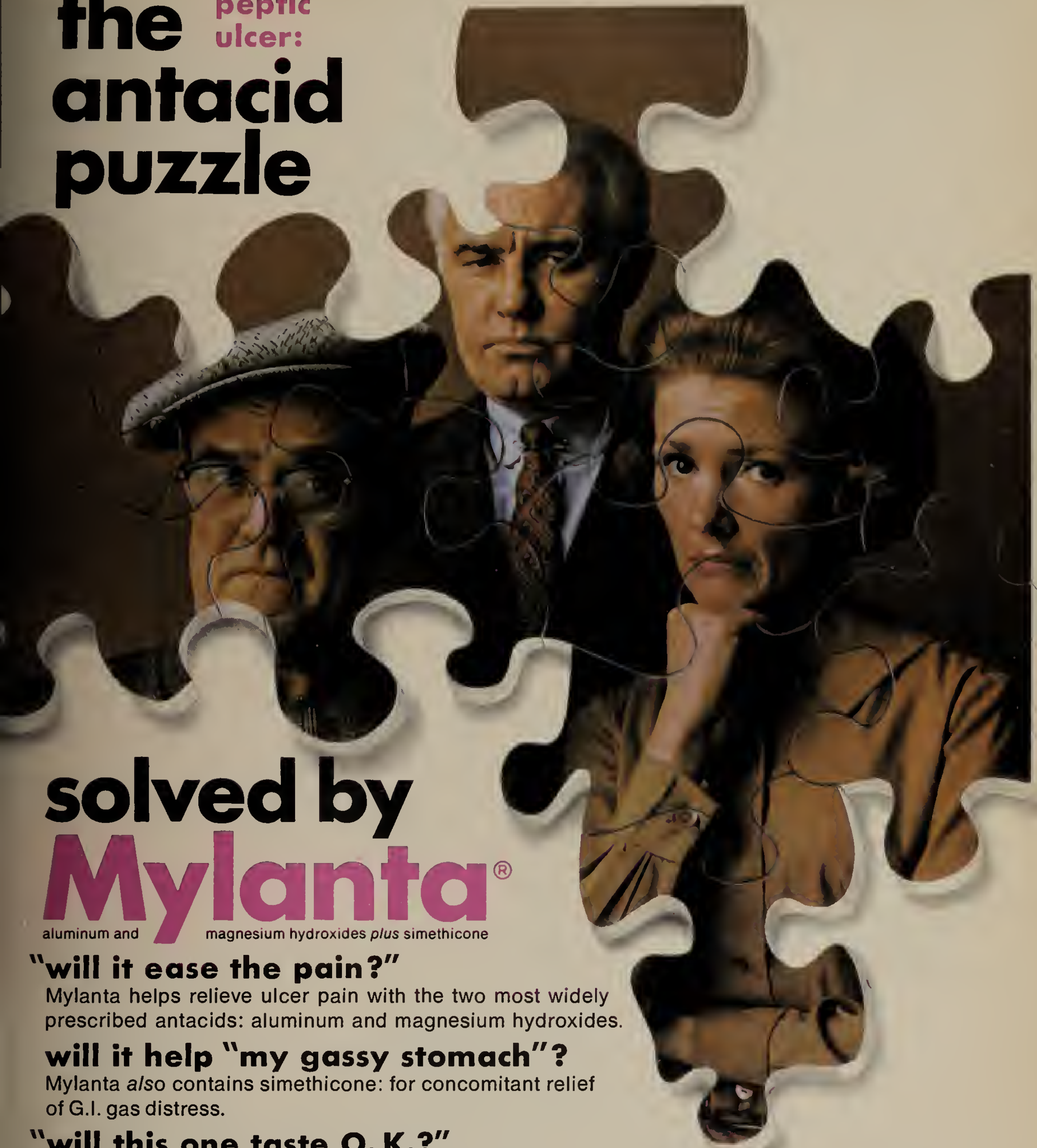
In peptic ulcer:

the antacid puzzle



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aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

No two women are quite alike...

Ovulen-21 Com
Directions

and no other oral contraceptive is quite like Ovulen-*21*®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive… together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. *2*:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. *2*:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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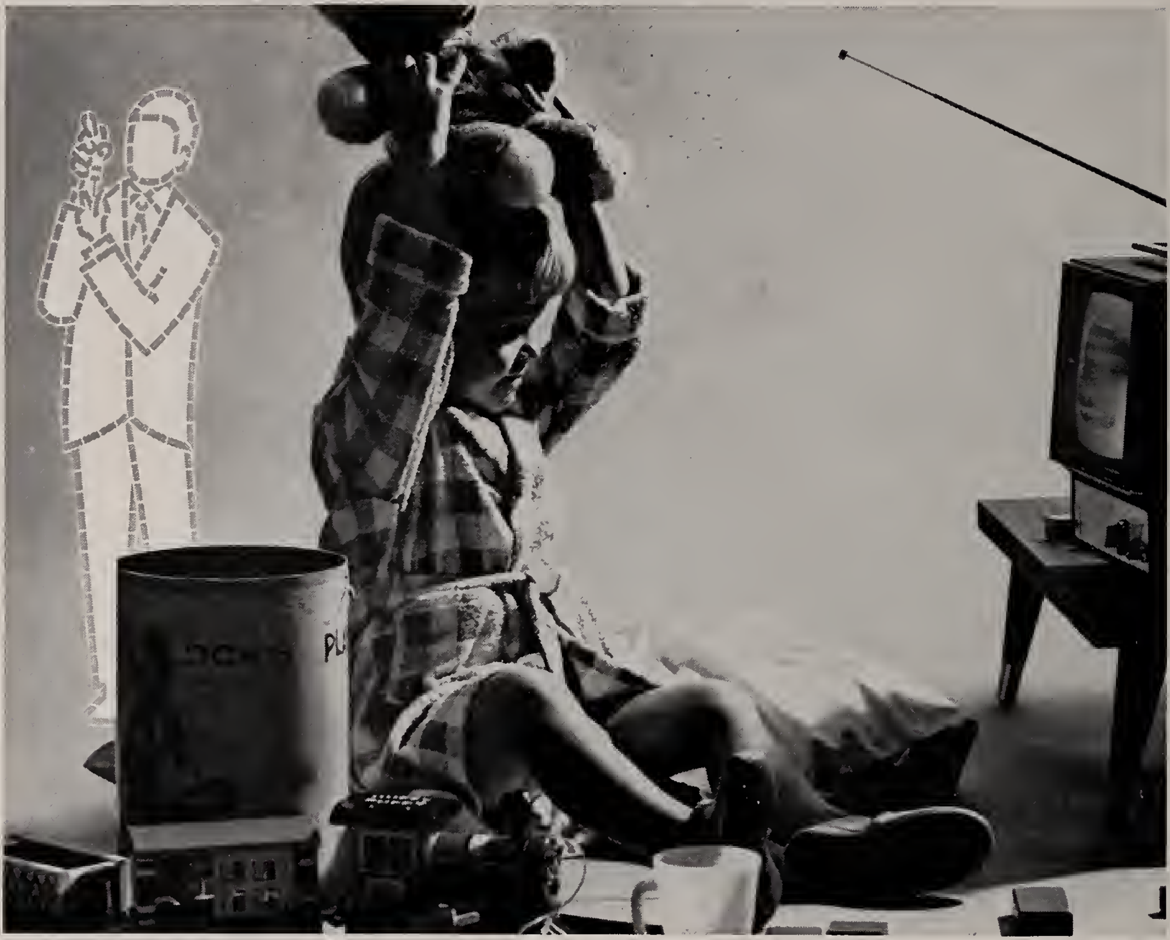

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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

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Concerning Therapy of Candida Fungemia

BY MARY M. CARRUTHERS, M.D.
A. MARTIN LERNER, M.D.
BOTH OF DETROIT

INTRODUCTION

When Candida fungemia is found, removal of the usually culpable intravenous catheter and cessation of antibiotics are indicated. If the patient does not improve, intravenous amphotericin B is instituted.[1-4] Mortality, however, remains high.

Within a 13 month-period, we saw 9 patients with nosocomial Candida fungemias. In each, at least 2 separate blood cultures yielded Candida. Four of the patients who died had received less than 24 hours of therapy with amphotericin B. We suggest prompt institution of small doses of amphotericin when candidemia is documented.

METHODS

Patients were admitted to medical or surgical wards of the Detroit General Hospital. Initially isolations of Candida were made in tryptose phosphate broth. Later, urine, swabs from the throat, feces, or pleural fluids were cultured on Sabouraud's agar. Subsequently, all Candida were transferred to eosin methylene blue (EMB) and Sabouraud's agar. Species were suspected by colonial morphology on EMB agar and characteristics of growth in broth. In most instances fungi were further delineated by biochemical reactions.

CLINICAL FINDINGS (SEE TABLE)

Characteristics of illness are presented in the table. Patients were 18 to 60 years old with a mean of 46 years. Five were women. Cases occurred during every season. Five were chronic alcoholics with abnormal liver function. One was in hepatic coma, and another had marked ascites. One had chronic renal disease with azotemia; 2 others had transiently elevated values of blood urea nitrogen which returned to normal before the onset of their candidemia. Two patients had diabetes mellitus, but their metabolic acidosis was probably renal. Other conditions necessitating hospitalization were empyema, peritonitis, a burn to 30% of the skin, and meningovascular syphilis. None of the patients had malignancies or had received immunosuppressive drugs. One had had corticosteroids. Antibiotics were used by mouth (5 patients) or parenterally by muscle (6 patients) or vein (5 patients). One patient had received 5 agents; three, 4 separate drugs; one, 3 drugs; and one, 2 drugs. Three patients received 1 antibacterial agent. These drugs (ampicillin, cephalothin, chloramphenicol, colistimethate, kanamycin, neomycin, penicillin G, streptomycin, sulfamethoxazole and tetracycline) were given for continuous periods of 6-39 days. Only a 55 year old woman entering in hepatic coma had received neomycin alone by mouth for less than a day. When candidemia was initially documented, all patients were receiving intravenous infusions and most of them by catheter.

Peaks in oral temperature were 102-103°F in 2 patients and 103-106°F in the rest. Moderate to marked anemias (6.5-9.5 gm/100ml) were present in 7 of the 9 patients before onset of fungemias. During candidemias most patients had leukocytoses and all had "shifts to the left." Although 2 patients had initial values of blood urea nitrogen which were transiently over 100 mg%, these returned toward normal before fungemia ensued. Both patients survived. In 3 of the fatal cases progressive azotemia accompanied fungemia. None of these patients had preexisting renal disease, and this organ failure seemed directly related to their candidemias. Serum glutamic oxalacetic transaminases were moderately elevated (less than 200 units) in 2 patients. Four patients with cirrhosis of the liver and one with peritonitis had rises in total bilirubin (2-12 mg/100 ml). Alkaline phosphatase levels were 6.8-26.2 Bodansky units in 3 patients. Hypoalbuminemia (less than 2.5 gm/100

This article was written by Mary M. Carruthers, M.D., during tenure as trainee in infectious diseases and Instructor in Medicine, Wayne State University School of Medicine, and by A. Martin Lerner, M.D., Professor of Medicine and Associate in Microbiology and Pathology, Wayne State University School of Medicine and also Chief of Infectious Diseases and Director of the Bacteriology Laboratory, Detroit General Hospital. The research was aided by a grant (5 T1 AI00261) from the National Institutes of Health. Requests for reprints should be addressed to Doctor Lerner, Wayne State University Medical Research Building, 550 E. Canfield, Detroit, Michigan 48201.

Dr. Carruthers is now Associate in Medicine at Chicago Medical School.

TABLE: Findings in 9 patients with Candida Fungemia at Detroit General Hospital during 13 months of 1966-67

A. HISTORY

AGE	
Range	18-60 years
Mean	46 "
SEX	
Male	4
Female	5
OCCURRENCE	
February	1 patient(s)
April	2 "
September	3 "
October	2 "
November	1 "
DIAGNOSIS AT ADMISSION	
Chronic alcoholism	5 patients
Cirrhosis with liver failure	2 "
Pyelonephritis	2 "
Diabetes mellitus	2 "
Chronic renal disease with azotemia, empyema, peritonitis, 30% burn, meningovascular syphilis	1 patient ea.
ANTIBIOTICS* GIVEN BEFORE FUNGEMIA	
Number of drugs	
5	1 patient(s)
4	3 "
3	1 "
2	1 "
1	3 "
ROUTE OF ADMINISTRATION	
Intravenous	5† patients
Intramuscular	6 "
Oral	5 "
DAYS OF ADMINISTRATION	
< 1	1 patient(s)
1-8	2 "
9-18	5 "
39	1 "

B. TEMPERATURE AND LABORATORY FINDINGS (DURING CANDIDEMIA)

Temperature peak °F (orally or equivalent)	
102-103	2 patients
103-106	7 patients
Hemoglobin (grams/100 ml)	
6.5-9.5	7 patients
10-11	2 patients
White blood cell count/ml	
< 10,000	2 patients
10-15,000	5 "
> 20,000	2 "
"Shift to the left"	9 patients
Plasma urea nitrogen (mg/100 ml)	
< 20	5 patient(s)
50-100	3 "
> 100	1 "
Creatinine (mg/100 ml)	
< 2	5 patient(s)
2-5	1 "
> 5	3 "
Serum glutamic-oxalacetic transaminase (units)	
100-200	2 patients
Total bilirubin (mg/100 ml)	
2-12	5 patients
Alkaline phosphatase (Bodansky units)	
6.8-26.2	3 patients
Serum proteins (grams/100 ml)	
Albumin < 2.5	3 patients
Globulin > 3.0	5 "
Yeast in urinary sediment	
Present	2 patients
Absent	3 "
Candida recovered	
Species/deaths	
albicans	4/4 patients
parakrusei	1/1 "
tropicalis	1/0 "
not albicans	3/1 "

Number of isolations from blood	total pts/death
4-6	3/2
3	3/2
2	3/2
Urine	3/1
Throat	1/1
Feces	2/0
Pleural effusion	1/1

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* These included ampicillin, cephalothin, chloramphenicol, colistimethate, kanamycin, neomycin, penicillin G, streptomycin, sulfamethoxazole, and tetracycline.

† All patients received intravenous fluids.

ml) was present in 3 patients, while 5 had hyperglobulinemia (over 3 gm/100 ml). All of these abnormalities in liver function antedated fungemia. Of 5 urines which were examined at times of fungemia, yeast was seen twice.

Species of *Candida* in the blood were *albicans* (4 patients), *tropicalis* (1 patient) and *parakrusei* (1 patient). Three candidemias were species other than *albicans,* but were not further characterized. Every *C. albicans* fungemia was fatal, while 2 of 3 patients with species other than *albicans* and the single patient with *C. tropicalis* sepsis recovered. The *C. parakrusei* infection was also fatal. Urines were cultured in 3 patients and in each, Candida was found. When feces was cultured (twice) or the throat (once), samples yielded Candida. Finally, a *Pasteurella multocida* empyema was superinfected with Candida. Usually within 48 hours blood cultures were positive. Fungemias were repeatedly documented and with a single exception, candidemias were found on at least 2 separate days. Four to 6 cultures from blood were positive in 5 patients, 3 positive in 3 patients and 2 positive in 3 patients. Candidemia was documented for less than 24 hours in 1 case and for 2-12 days in the other 8. Five of 6 patients died whose fungemias were documented for 3 days or less, while 2 of the 3 patients whose fungemias were documented for 7 or more days survived. After the first isolation of Candida from blood, 1 patient lived less than 48 hours while 5 others survived 3-16 days.

TABLE/Continued

C. COURSE

Duration of documented candidemia	total pts/deaths
1 day(s)	1/1
2 "	3/2
3 "	2/2
7 "	2/0
12 "	1/1

D. AMPHOTERICIN B THERAPY

	total pts/deaths
None	4/3
< 24 hours	1/1
48 hours-6 days	4/2

E. DURATION OF ONSET OF CANDIDEMIA TO DEATHS

2 days	1 patient(s)
3 "	1 "
5 "	1 "
9-16 "	3 "
living	3 "

Four patients received no amphotericin B. Three of them died. A 60 year old woman with cirrhosis and *P. multocida* empyema received a single infusion of 15 mg of amphotericin B. before her demise, while 2 of the patients receiving longer courses survived. In 2 of the survivors, initiation of therapy with an initial dosage of 5 mg amphotericin B promptly cleared the blood of fungi. In both patients, where candidemia had previously been found for periods of 48 hours and 7 days respectively, amphotericin B in daily infusions of 15-30 mg was continued for 6 days. Cessation of candidemia in at least one patient, a 45 year old man with pyelonephritis and diabetes mellitus, was not the result of removal of an intravenous catheter. A hectic fever and leukocytosis continued for 2 weeks after intraveous fluids, and all antibiotics were discontinued. *C. tropicalis* fungemia was documented on 4 separate occasions over a 7 day period. After administration of amphotericin B, fungemia ceased.

COMMENT

These patients with candidemias were all debilitated. However, hepatic and renal diseases, diabetes mellitus or other conditions were stable when high fevers and leukocytoses appeared. All had been given intravenous infusions usually by an indwelling catheter. All but one* of the patients had received at least one broad-spectrum antibiotic. *C. albicans*[5] was most virulent, and all of these patients died. Three of the 5 patients with species other than *albicans* recovered. Oligemia or rising azotemia occurred in 3 of the fatalities.

Amphotericin B is indicated in candidemia only after antibiotics are discontinued and infected catheters removed. In one of our patients, candidemia continued for at least 8 days following cessation of intravenous and antibacterial therapy. In 2 of the survivors when amphotericin B was promptly administered small amounts of drug rapidly ended the fungemia. In these amounts there was no toxicity from amphotericin B.

Candida are readily recoverable with routine bacteriologic media from the blood and rarely are contaminants in this site. Yeast probably originated from infected phlebitic veins in patients with intravenous catheters. However, spontaneous gram-negative bacillemias occur in cirrhotics,[6] and although similar candidemias especially in these patients who lack a circulating globulin lethal for *C. albicans* are possible*[7] this remains conjecture. Systemic candidiasis in man may be remarkably similar to the murine model. In both, the kidney is the most vulnerable organ and rapidly progressive renal failure the mode of death. In the mouse after candidemias of 24-30 hours, microabscesses are found in the liver, pancreas, heart, skeletal muscle, and kidney. Occasionally rupture of the fungus into the lumina of the nephron occurs. Within the urine (free of protective globulins in serum) fungi multiply rapidly forming long invasive hyphal elements. Lesions in other organs invariably regress, but occasional recurrent interstitial invasion by hyphae leads to large and lethal cortical and medullary abscesses.[8] An objective of therapy may be to prevent such secondary hyphal invasion of the kidney. Gross and microscopical abscesses in the kidney and brain were demonstrated in one of the fatalities.

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*This patient was receiving 30 million units of intravenous penicillin G daily.

Candidemia should be considered in any patient developing a fever and leukocytosis with an intravenous catheter, especially while receiving antibiotics. The catheter should be removed. A single positive blood culture for Candida suggests that amphotericin B be initiated. Infusions of 15-30 mg daily for about a week have no toxicity, and may be life-saving.

SUMMARY

Nine patients with candidemias were seen at the Detroit General Hospital within 13 months of 1966-67. All had chronic underlying illnesses requiring hospitalization. Hectic fevers and leukocytoses with "shifts to the left" heralded fungemias. Most of the patients had intravenous catheters, and all were receiving antibacterial agents. Corticosteroids were administered to one, but none received immunosuppressive drugs. None had malignancy. Six died after illnesses of 48 hours to 16 days. In at least one of the survivors small doses of amphotericin B induced a prompt remission which did not follow removal of an intravenous catheter and cessation of antibacterial agents.

Since removal of the intravenous catheter followed by a period of observation is not always successful, it is suggested that 15-30 mg of amphotericin B intravenously should be promptly administered when candidemia is confirmed.

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Editorial Comment:

Candida is ordinarily a benign fungus of little consequence. Two factors in modern medical therapy appear to be unleashing a potential danger. These two factors are the use of antibiotics and indwelling catheters. The authors point out warning signs of Candida fungemia, laboratory detection and the need for specific therapy.

—John W. Moses, M.D.,
Scientific Editor

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*Patients with diabetic or renal acidosis as well as others with systemic candidiasis are also deficient in this substance.

Clinical Pathological Conference

This Clinical Pathological Conference at Munson Medical Center, Traverse City, was edited by Richard Wunsch, M.D., Michigan Medicine Associate Scientific Editor of Traverse City

A 56-year-old woman came to the hospital because of fatigue, chronic cough, and hypertension.

During the three years before admission, the patient was aware of progressive fatigue, severe enough to prevent her from performing ordinary household tasks or from walking one to two blocks. Within the last month she developed a persistent non-productive cough and X-rays showed only increased bronchovascular markings. The patient had had hypertension and during a physical examination approximately eight months previously, the blood pressure was 240/130 mm. Hg. Quinidine controlled episodes of tachycardia and auricular fibrillation.

The patient denied pain associated with fatigue. There was no intolerance to cold or heat nor had there been episodes of paroxysmal nocturnal dyspnea. The patient stated that she had had rheumatic fever approximately 20 years ago and ascribed occasional pain in both ankles as an aftermath of that disease. The patient developed what she termed "butterflies" in the abdomen and there were occasional bouts of constipation.

A brother of the patient has diabetes mellitus and another brother and her mother died of coronary thrombosis.

PHYSICAL EXAMINATION

The patient was alert but replied rather slowly to questions. Blood pressure, 148/80, pulse 60 per minute, respirations 20 per minute, weight 179 lbs. There was a suggestion of fullness when examining the thyroid, but nodules were not palpable. The left border of cardiac dullness extended to the left anterior axillary line. The rhythm was normal and a Grade II systolic murmur was heard over the apex and to a lesser extent at the base of the heart. Lungs were clear to percussion and ausculation. Abdominal, pelvic and rectal examinations were normal. The skin felt dry and thickened but there was no edema. The neurologic examination was within normal limits although ankle jerks were not elicited bilaterally.

About the Hospital:

This CPC is from the Munson Medical Center, a nonprofit community hospital at Traverse City, a city of 20,000 on Grand Traverse Bay. The hospital, which serves as a referral center for the area, has 250 beds and a training program with rotating internships.

INITIAL LABORATORY DATA

C.B.C.: Hemoglobin, 15.5 gm/100 ml.; wbc, 13,500 per mm^3 with 8% bands, 63% segs, 1% eosinophils, 3% basophils, 22% lymphocytes, and 3% monocytes.

Urinalysis: Specific gravity 1.012 albumin, trace; other chemical tests normal, 3 to 5 white blood cells per high power field on microscopic examination.

Chemical testing: fasting blood sugar, 92 mg/100 ml; blood urea nitrogen, 45 mg/100 ml; total protein 6.6 G/100 ml; protein electrophoresis, albumin 3.3 G., alpha one 0.03 G., alpha two 0.08 G., beta 0.7 G., and gamma 1.3 G. (all values were within normal limits although the gammaglobulin fraction was at the higher range of normal).

* * *

Maurice Pelto, M.D.,
Radiology Department

X-RAYS

A limited number of radiologic examinations were available. The first, a chest, showed mild to moderate cardiomegaly with left ventricular prominence, and a prominent aortic arch. The hilar shadows were minimally prominent apparently on the basis of enlarged main pulmonary arteries. **(Figure 1)**

Subsequent cardiac films, taken three days later, including obliques with barium, confirmed the prominent aortic arch. Fluoroscopy showed pulsation of the hili favoring prominent pulmonary arteries. They had a somewhat rounded appearance and one could not exclude adenopathy. The enlarged aortic arch with its increased pulsations made

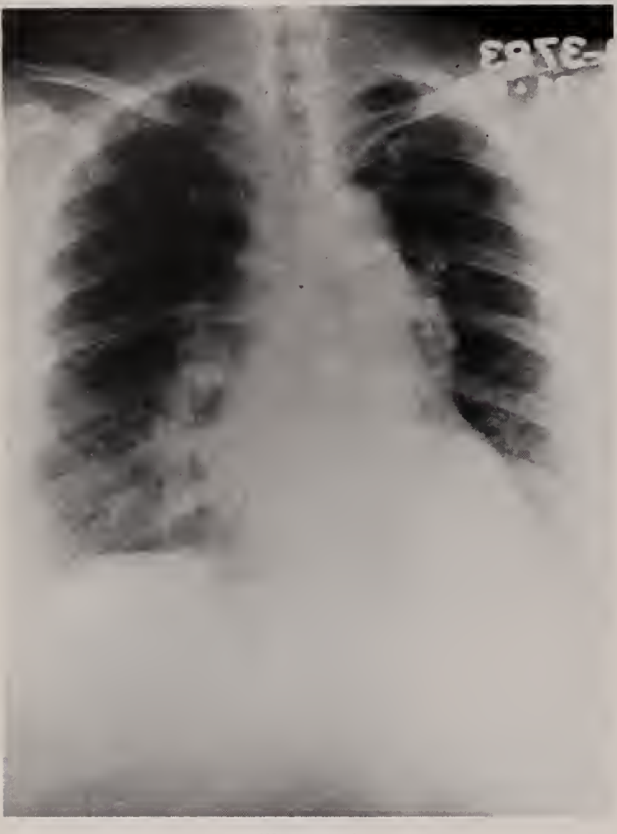

Figure 1

adequate evaluation and differentiation difficult. Laminograms added no further information. An IVP at the time showed mild delay in contrast excretion bilaterally, and was otherwise normal. There was splenomegaly of moderate extent.

Because of the confusion concerning the hili, a miniature chest film taken four years previously was obtained. This showed a similar degree of cardiac enlargement and hilar prominence. In summary, the radiographic examinations showed a moderate cardiomegaly with a widened thoracic aorta, which pulsated prominently. The hili were prominent, the appearance favoring enlarged main pulmonary arteries, with no change in four years.

The kidneys showed mild decreased excretion of dye. There was moderate splenomegaly.

HOSPITAL COURSE

The patient's condition remained unchanged. Additional laboratory studies included: serum calcium 11.9 mg/100 ml. phosphorus 3.3 mg/100 ml., fasting blood sugar 136 mg/100 ml, serum chloride 104 mEq/1, sodium 149 mEq/1, and potassium 4.1 mEq/1. White blood count 18,600 per mm^3 with a normal differential.

Early in the morning of the 10th hospital day she complained of nausea and vomited undigested food. Severe abdominal pain developed and the temperature rose to 101° F. Serum amylase was 2,250 Somogyi units. Serum electrolyte values were in the normal range. Intravenous fluids were administered because of clinical dehydration. On the 11th day, the temperature rose to 106° F. and a repeat serum amylase was 1,330 Somogyi Units. Blood pressure decreased gradually to 86/56 mm. Hg. and the patient was placed in an oxygen tent because of cyanosis. On the 12th day her condition remained critical and urinary output diminished to less than 500 ml. for 24 hours. Serum sodium was 118 mEq/1, chloride 84, potassium 6.9, serum calcium 9.2 mg/100 ml., carbon dioxide content 21.3 mEq/1, serum bilirubin 6.8 mg/100 ml. with a direct fraction of 4.8 mg/100 ml. The temperature remained elevated in the range of 104° to 105° F. She became unresponsive and died on the 12th hospital day.

* * *

DISCUSSION

* * *

Jerold Harwood, M.D.,
Department of Medicine

Fatigue apparently consisting of asthenia and myasthenia was the chief complaint at the time of admission of this middle-aged woman. The protocol does not describe the course of hypertension but does note the occurrence of paroxysmal arrhythmias. The exertional dyspnea and persistent cough suggested mild congestive heart failure. The history of acute rheumatic fever was poorly documented and consists only of sore ankles which had persisted for 20 years. Hypertension and a family history of diabetes mellitus and coronary artery disease established a good background for the presence of arteriosclerotic heart disease.

The physical examination was surprising in that the blood pressure was normal and there were no findings of congestive heart failure except cardiac enlargement. No stigmata of sustained hypertension were described. No neuromuscular abnormality was described except depressed tendon reflexes. The localized thyroid enlargement was interpreted as non-adenomatous for unknown reasons. Laboratory tests established the presence of azotemia, hypercalcemia, hyperglycemia and perhaps a mild hypergammaglobulinemia. The urinalysis did not reflect the severity of the uremia. The chest x-ray was described as showing generalized cardiac enlargement with aortic and pulmonic artery prominence interpreted as aortic valve disease and pulmonary hypertension.

Her terminal course was marked by the development of an acute abdomen with hyperamylasemia, direct hyperbilirubinemia and shock. The sodium, chloride and calcium were all observed to decrease during this period.

The definable problems were the 1) hypercalcemia, 2) acute abdomen, 3) uremia, 4) hypertension, and 5) cardiac enlargement.

Diagnosis of the hypercalcemia was difficult because of only a single phosphorus determination and no alkaline phosphatase measurement. Hypergammaglabulinemia, proteinuria, and a normal serum phosphorus suggested multiple myeloma. The hypergammaglobulinemia of multiple myeloma is usually more dramatic and occurs as a monoclonal spike on electrophoresis. Anemia and rouleaux formations are both manifestations of bone marrow replacement with cells producing abnormal globulin and are not described on our protocol. Sarcoidosis was a possible cause of the hypercalcemia, hypergammaglobulinemia and arthralgias. No hilar or peripheral adenopathy, pulmonary infiltrates or erythema nodosum were present. Minimal pulmonary sarcoidosis can cause a diffusion defect[2] but not pulmonary hypertension.

A history of upper gastrointestinal symptoms suggested the possibility of milk alkali syndrome but would not cause elevation of the serum phosphorus. No history of vitamin D ingestion was available as a possible source of hypercalcemia and this also should cause hyperphosphatemia. Chronic renal insufficiency can result in sustained parathyroid stimulation with the late development of hypercalcemia but always in the presence of, and because of marked hyperphosphatemia. Acute osteoporosis of disuse can not be implicated as a cause of hypercalcemia here. Hyperparathyroidism can not be excluded as the cause of her hypercalcemia. A single normal serum phosphorus does not rule out hyperparathyroidism and multiple phosphorus determinations may be required to demonstrate the hypophosphatemia. I have seen more than one surgically proven hyperfunctioning parathyroid adenoma accompanied by a normal serum phosphorus at the time of admission. The serum chloride of 104 mEq/l is highly suggestive of hyperparathyroidism opposed to hypercalcemic sarcoidosis in which the serum chloride is usually less than 102 mEq/l[9]. Studies of tubular reabsorption of phosphorus would not be of value in this case because of the impaired renal function.

The terminal event was quite dramatic and with its rapid downhill course, acute abdomen, shock, amylasemia and direct hyperbilirubinemia was strongly suggestive of an acute necrotizing pancreatitis. Acute pancreatitis is quite common (12%)[4] in the presence of hyperparathyroidism and may be the presenting event. A decrease in serum calcium due to diminished gastrointestinal absorption occurs in acute pancreatitis and usually parallels the severity of the pancreatitis. This phenomenon is so common that the presence of a normal serum calcium in the presence of acute pancreatitis is highly suggestive of hyperparathyroidism.[6] Acute pancreatitis is uncommon in hypercalcemia not due to hyperparathyroidism and the only case which I have read of was with a multiple myeloma.[1] Pancreatitis may be secondary to uremia of any cause and this should be kept in mind.

Carcinoma of the pancreas secreting a parathormone-like substance resulting in a hypercalcemia is conceivable but I'm not aware of any previously reported cases.

It is difficult to determine the duration of the uremia. Her longstanding, non-specific fatigue could be attributed to it, but chronic renal insufficiency would be expected to have a more striking hyperphosphatemia, hyperkalemia, anemia, hyposthenuria and albuminuria. Chronic glomerulonephritis and pyelonephritis would be expected to follow the latter course. Myeloma kidney or a kidney with glomerular and tubular dysfunction secondary to paramyloid deposits could cause this picture. Apparently benign essential hypertension can result in arteriolonephrosclerosis severe enough to cause renal failure. Renal failure secondary to heart disease is usually precipitated by a marked fall in cardiac output severe enough to cause shock and/or gross pulmonary and/or peripheral edema. No hematuria was present to suggest a primary arteritis which could also cause an acute intestinal event. Hypercalcemic nephropathy may be insidious in its onset and progress to terminal renal failure with a relatively normal urinalysis[3] and no roentgenological evidence of nephrolithiasis or nephrocalcinosis.[5]

The possibility of hyperparathyroidism looks quite strong. If one endocrine adenoma is present, I had best look for another one. Pheochromocytoma has a known association with parathyroid adenoma[7] and would explain the hyperglycemia, intermittent hypertension, paroxysmal arrhythmias and weakness and nervousness. Against this diagnosis is the body weight of 179 pounds which is quite husky for pheochromocytoma. Aldosteronism could account for hypernatremia, hyperglycemia, myasthenia and hypertension, but the normal-to-elevated serum potassium is against this diagnosis. The nephropathy of Conn's syndrome is almost always limited to impaired tubular function with hyposthenuria due to hypokalemia. Essential hypertension or renovascular disease with secondary hypertension are impossible to exclude. Renovascular disease with hypertension is unlikely in that the hypertension is not progressive and apparently preceded the renal disease.

The cardiac enlargement was one of the most difficult aspects of the problem. Arteriosclerotic heart disease unrelated to the other events would be expected to cause angina and more classical congestive heart failure. No physical findings of left ventricular hypertrophy were described so I will assume that the heart was dilated rather than hypertrophied. As mentioned before, it is hard to implicate sarcoidosis. Sustained catecholamine release from a pheochromocytoma can cause myocardopathy. Pheochromocytoma can also metastasize to heart and cause apparent valvular abnormality. Rheumatic heart disease with aortic stenosis and mitral insufficiency could result in the vascular changes described but does not relate to any other of her disease processes. Congenital heart disease with a left to right shunt and secondary pulmonary hypertension would not be expected to have hypertension or aortic prominence. Hypercalcemia can result in aortic valvular calcification and a myocardopathy which is as acceptable as any of the other etiologies mentioned. Cardiac amyloidosis secondary to multiple myeloma could also cause bizarre cardiopulmonary findings including aortic disease, arrhythmias and right sided dilatation with minimal pulmonary disease.

If the patient has a concurrent parathyroid adenoma and pheochromocytoma, the literature says that she must also have medullary carcinoma of the thyroid,[7] and this would account for the enlarged thyroid isthmus.

My diagnosis is Sipple's syndrome[8] or parathyroid adenoma — pheochromocytoma and medullary thyroid carcinoma with secondary acute pancreatitis, myocardopathy and hypercalcemic nephropathy. Second choice is multiple myeloma with hypercalcemia and secondary amyloidosis.

* * *

Laurence P. Skendzel, M.D.,
Department of Pathology

AUTOPSY REPORT

Outstanding gross and microscopic features were seen in the lungs, lymph nodes, pancreas and kidneys. The lungs were not remarkable grossly, but microscopic sections showed non-caseating granulomas composed on multi-nucleated giant cells surrounded by fibrous tissues. There was also an infiltrate of chronic inflammatory cells, chiefly lymphocytes. Sections through hilar lymph nodes showed similar microscopic findings, namely noncaseating granulomas, and in one of these, an asteroid body was seen. Stains for acid fast organisms and fungi were negative.

The pancreas was removed with difficulty because of adherence of its surface to the mesentary and loops of small and large intestine. The peritoneal surface overlying the pancreas was discolored and dark red; and there were numerous bright yellow foci of fat necrosis. The weight of the pancreas was 300 grams and included a moderate amount of soft tissue surrounding the head. Cut section showed discrete pancreatic lobules but the major portion of the pancreas was mottled red and green with a loss of normal architecture. Microscopic sections confirmed the gross impression of acute necrotizing pancreatitis.

Microscopic section of kidney showed focal glomerular thickening characterized by irregular deposits of pink staining material. Congo red and crystal violet stains were negative and ruled out the possibility of amyloidosis. The homogenous refractile material was positive with PAS stains. Microscopic findings were those of a focal glomerulonephritis characterized by thickening of glomerular walls. There also were calcific deposits in the interstitium of the kidney and arterioles were thickened considerably with narrowing of the lumens. The glomerular lesions were not classified. Focal glomerulonephritis can occur as a complication of a great variety of infections, chemical poisoning, or an allergic reaction to drugs. The thyroid was not enlarged nor were microscopic sections unusual. Only two parathyroids were identified at the time of autopsy and they were not enlarged.

The heart weighed 460 grams and the right ventricular wall was 0.4 cm. thick and the left ventricular wall, 1.2 cm. thick. Cross sections of the coronary artery shows that the lumens were patent. Microscopic sections of the heart were not remarkable. On examination of the lung, focal arteriosclerosis was noted in the pulmonary arteries. There was no significant enlargement of the major pulmonary arteries at the hilum.

The microscopic findings in the lungs and lymph nodes were consistent with sarcoidosis. We attributed hypercalcemia to sarcoidosis and the serum calcium concentration decreased with the onset of acute pancreatitis. We were aware of the association between hyperparathyroidism and pancreatic disease, but a review of the literature does not reveal a correlation between sarcoidosis and acute pancreatitis.

FINAL ANATOMIC DIAGNOSES:

1. Sarcoidosis involving lungs and hilar lymph nodes.

2. Acute necrotizing pancreatitis with fat necrosis of peri-pancreatic tissue, omentum, and mesentary of small and large intestine.
3. Focal glomerulonephritis.
4. Arteriolar nephrosclerosis.
5. Enlargement of the heart, slight, weight 460 grams.

* * *

FURTHER DISCUSSION

A physician:

In retrospect, what clues suggested the diagnosis of sarcoidosis?

Doctor Harwood:

Hypergammaglobulinemia and hypercalcemia would make you consider this diagnosis. The features against sarcoidosis are the elevated serum chloride level, about 104 mEq/l, the fact that acute pancreatitis has not been described in association with sarcoidosis. This would be a reportable case except for the fact that all the parathyroid glands were not identified.

A physician:

We are aware of the association of parathyroid tumors in pancreatitis, and one wonders if the high calcium level is responsible for acute pancreatitis?

Doctor Harwood:

Acute pancreatitis associated with hyperparathyroidism is due to a direct action of parathyroid hormone on trypsin activation in the pancreas. The calcium level is not responsible for the acute pancreatitis.

Doctor Pelto:

I'm wondering if the prominence in the hilar regions were lymph nodes instead of pulmonary arteries. I have a feeling that the one feature that led the Discussant astray is the confusion of enlarged pulmonary wessels with hilar adenopathy.

Doctor Skendzel:

There was no enlargement of the pulmonary arteries. The autopsy protocol does not include the measurement of lymph nodes, but I assume that they were enlarged.

A physician:

I have a young woman with asymptomatic sarcoidosis and a proven Kviem test. Chest X-Rays on two occasions have shown prominent pulmonary arteries.

A physician:

One interesting feature that I have seen before in sarcoidosis is dyspnea which can not be explained on the basis of pulmonary findings. The enlarged spleen noted on the I.V.P. is another possible clue of sarcoidosis.

Doctor Harwood:

Pulmonary function tests would have been extremely valuable in this case. In the *"Annals of Internal Medicine"* a study showed that with either minimal sarcoidosis or extensive sarcoidosis which has been treated and dissolved, there is a persistent pulmonary defect even though the pulmonary architecture is not remarkable.

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The Physician as a Life-Long Student

BY MILFORD O. ROUSE, M.D.
AMA PAST PRESIDENT
DALLAS

The true physician is a student as long as he accepts the responsibility of practicing medicine. Even if the store of medical knowledge were not doubling every ten years — as has been estimated, it would be impossible for any human brain to absorb and retrieve all of the scientific knowledge requisite for the "complete" practice of medicine. The physician, therefore, learns the essentials or fundamentals of medicine and where to go for special information, and then relies on his judgment and his sincere desire to "keep-up" to enable him to continue to meet faithfully his obligation in handling the problems of health of his fellow citizens.

Therefore, postgraduate or continuing education is a vital necessity for every physician.

In addition to the every day opportunity to learn from his patients and from his fellow physicians, a doctor should also have a definite program of continuing education by scientific reading. His county medical bulletin, his state medical journal, the Journal of the American Medical Association, his specialty journal (if he is in a specialty) ought to be the minimum — with at least a couple of hours set aside each week to at least scan through these journals.

The scientific programs of his county society; annual meeting of his state association; the annual and clinical sessions of the AMA and the meetings of his specialty groups afford a wonderful opportunity to get a condensed review of both fundamentals and advancements in the fields in which the physician is particularly interested.

The American Academy of General Practice set the first example of requiring a minimum amount of postgraduate work as a basic requirement for continued membership in the organization, and other medical groups are considering the same principles. Most of our medical schools have excellent programs of continuing medical education, and many specialty groups sponsor one week or more organized postgraduate work one or more times each year.

One interesting advance has been the utilization of closed circuit television — not only from hospital or medical school to assembly hall or hotel room during medical meetings, but now from a medical center to a county medical society, as was recently successfully demonstrated between the Southwestern Medical School Faculty in Dallas and a group assembled at Sherman, Texas, for the Blackford Memorial Lectures, where a clinical pathological conference was staged in the most successful and interesting manner, with questions and comments both from the audience in Sherman and the team in Dallas.

The American Medical Association is working on plans of formal recognition of regular postgraduate work by physicians, probably as a plaque to go on the physician's wall.

Meanwhile, the true physician regards continuing medical education not only as an obligation, but as a tremendously interesting privilege.

(Editor's Note: This article was prepared by Doctor Rouse especially for Michigan Medicine).

Tumors of Major Salivary Glands In Children

BY KLAUS HOFFMANN, M.D.
MELVIN A. BLOCK, M.D.
BOTH OF DETROIT

Except for hemangioendotheliomas, angiomas, and other congenital lesions which usually are evident during the first year of life, the spectrum of disease processes producing tumors of the major salivary glands in children is similar to that in adults.

Our experience emphasizes that unless management of salivary gland lesions in children follows the principles established for their proper treatment in adults, recurrence rates and the incidence of poor therapeutic results are high. Thus, tumors of the parotid gland in children require more than a local excision; i.e., at least a partial or superficial parotidectomy should be performed.

MATERIALS AND METHODS

In a review of the experience with lesions of the major salivary glands at the Henry Ford Hospital from 1944 through 1966, 22 patients were under the age of 16 at the time the tumors of these glands were recognized. All patients with acute inflammatory processes involving the salivary glands were excluded. All lesions occurred in the parotid gland except for three patients in whom the submaxillary gland was involved. This distribution of the various pathologic entities in the 22 patients is shown in **Table I.**

Follow-up periods varied from 2 to 23 years, with an average of 13 years. The operative procedures, along with the results of treatment and the length of follow-up periods, are shown in **Table II.**

RESULTS

Since a total of 440 tumors of the parotid and submaxillary glands were treated at the Henry Ford Hospital from 1944 through 1966, approximately 5 per cent of all patients with tumors of the major salivary glands were 16 years of age or less. This figure agrees with that of other investigators.[1]

Of the four patients with persistent salivary gland enlargement due to chronic sialadenitis, three required resections because of persistent symptomatic enlargement. In one of the patients, ductal obstruction, due to a stone, was shown to be the etiologic factor. The additional patient, who did not require an operation, had bilateral parotid involvement. Antibiotics were used in treatment.

As shown in **Table II**, problems in treatment were concerned primarily with mixed tumors and mucoepidermoid tumors in children. Difficulty occurred as a result of inadequate initial operative procedures.

Of seven children having mixed tumors of the parotid, two were seen initially because of local recurrence following a previous local excision. One of these patients had been operated for a mixed tumor on two previous occasions. Wider excisions, usually a subtotal parotidectomy, has not been followed by further difficulty for follow-up periods of 3 to 18 years.

All four children with mucoepidermoid tumors were seen because of recurrence, for the third time in one patient, following previous excisions. In one patient, cervical lymph node dissection for metastatic spread was necessary at the time of reoperation.

DISCUSSION

The frequency of occurrence and high recurrence rate of mixed tumors and mucoepidermoid tumors, after local excision of salivary gland tumors in children was striking in this review. The potential danger of salivary gland tumors in children is emphasized.

A tumor of a major salivary gland in infancy can be expected to be a hemangioendothelioma or angiomatous lesion of congenital origin. Kauffman and Stout report benign hemangioendotheliomas to be the dominant tumors of the parotid in the first year of life.[2] They point out that this pathologic entity is the most striking feature distinguishing parotid tumors in infants and children from those occurring in adults. Surgical removal of hemangioendotheliomas, hemangiomas,

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Both authors, Doctor Hoffmann and Doctor Block are associated with the Department of General Surgery, Henry Ford Hospital, Detroit.

TABLE I. LESIONS OF PAROTID AND SUBMAXILLARY GLANDS IN 22 PATIENTS UNDER THE AGE OF 16 YEARS.

	LESION	NO. PATIENTS	AGES
I. Infancy and early childhood	Hemangioendothelioma	2	1-2 mo.
	Lymphangioma	1	3 yr.
II. Childhood	Chronic sialadenitis, non-specific*	4	6-16 yr.
	Tuberculous sialadenitis	1	7 yr.
	Simple cyst	1	6 yr.
	Epidermoid cyst*	1	9 yr.
	Mixed tumor*	7	8-16 yr.
	Mucoepidermoid tumor	4	11-14 yr.
	Acinar cell carcinoma	1	13 yr.
TOTAL		22	

*One each of these categories occurred in submaxillary gland.

TABLE II. OPERATIONS AND RESULTS OF TREATMENT FOR MAJOR SALIVARY GLAND LESIONS IN CHILDREN.

LESION	NO. PTS.	ORIGINAL OPERATION	RECURRENCE	FINAL OPERATION	CURRENT STATUS	LENGTH OF FOLLOW-UP (YR.)
Hemangioendothelioma	2	Part. parotidect.	No (2)	———	No rec.	3-15
Lymphangioma	1	Superficial parotidect.	No	———	No rec.	2
Chronic sialadenitis, non-specific	4	Subtot. parotidect. (2) Excision submax. gland (1) No operation (1)	No (4)	———	No rec.	6-19
Tuberculous sialadenitis	1	Subtot. parotidect.	No	———	No rec.	13
Simple cyst	1	Superficial parotidect.	No	———	No rec.	2
Epidermoid cyst	1	Excision submax. gland	No	———	No rec.	10
Mixed tumor	7	Local excision (4)	Rec. (2)*	Subtot. (2) parotidect.	No rec.	4-22
		Excision submax. gland (1)	No	———	No rec.	
		Subtot. parotidect. (2)	No	———	No rec.	
Mucoepidermoid tumor	4	Local excision (4)	Rec. (4)**	Subtot. (2) parotidect. Total (2) parotidect.	No rec. in 3, 1 lost to follow-up	2-20
Acinar cell carcinoma	1	Superficial parotidect.	No	———	No rec.	4

*In one patient, recurrence developed on 2 occasions after local excisions done prior to subtotal parotidectomy.

**In one patient, recurrence developed on 3 occasions after local excisions prior to more madical operations. Neck dissection also done in 1 patient having cervical node metastases.

and lymphangiomas is avoided if possible during the first two years of life since facial nerve damage is prone to occur and some of the lesions will regress. A small incisional biopsy is performed to eliminate the possibility of a rare sarcoma or embryoma which should be totally removed by parotidectomy.[3] Early removal of benign congenital lesions may be necessitated because of size, ulceration, or hemorrhage.

Except for the finding of undifferentiated carcinoma occurring more frequently in childhood (beyond infancy) than in adults, the spectrum of pathology and the clinical behavior of lesions of major salivary glands is the same in children as in adults.[2] Chronic sialadenitis can produce persistent tumefaction and constitutional symptoms in children as well as in adults. Blatt states that benign lymphosialadenopathy in children is characterized by a non-obstructive peripheral duct sialectasis.[4] However, chronic sialadenitis of the submaxillary gland in a 16 year old boy in our group was associated with a stone in the duct. Total extirpation of a submaxillary gland because of repeated inflammatory exacerbations associated with a calculus was also required for a seven year old patient reported by Doku.[5] As Beahrs, Devine, and Woolner point out, parotidectomy is indicated when symptoms of chronic or recurrent sialadenitis are severe and do not respond to conservative treatment.[6] Blatt also emphasized that recurrent and persistent parotid lymphadenitis can result from animal scratches.[4]

Karlan and Snyder emphasize that chronic sialadenitis causes the majority of persistent salivary gland enlargements and can usually be managed satisfactorily by observation and antibiotics.[7] Extensive parotid surgery for inflammatory lesions is associated with a greater risk of facial nerve damage in children. In general, chronic inflammatory lesions of the salivary glands were not included in this series unless the persistent enlargement produced significant symptoms or problems in differentiation from a neoplasm.

The histologic identity of discrete nodules or tumors of major salivary glands cannot be defined with certainty except by study after surgical removal. Therefore, all such gross lesions in the parotid should be treated by at least a superficial parotidectomy (removing the portion of the gland superficial to the facial nerve) and those in the submaxillary gland by total excision of this gland, as the minimal operative procedure. This study emphasizes the necessity for this policy in children as well as in adults. A high local recurrence rate, metastatic spread, or other complications occur following removal of mixed tumors, mucoepidermoid tumors, or more virulent lesions, or more malignant lesions unless this policy is followed in operative procedures for all ages beyond infancy. Every effort should be made to preserve the facial nerve and its major branches, if these are not involved as evidenced by pre-operative or operative findings. Of course, preservation of branches of the facial nerve can necessitate a more tedious and difficult dissection in young children. Tumors of the deep portion of the parotid gland are rare; these require removal of this portion of the gland by an approach through the neck.

It is true that discrete small tumors projecting from the lower pole of the parotid can occasionally be adequately removed by a wide excision of the lower half of the gland (partial parotidectomy) after proper visualization of the facial nerve and its branches. Also, in rare instances incisional biopsy is indicated to determine the nature of large diffuse lesions in infants or young children to support a policy of continued conservative treatment for a chronic inflammatory process. Siaglograms are also of help in such problems. Thus, experienced surgical judgment modifies treatment, but the policy stipulated in the above paragraph should be the basic plan of management of parotid tumors in children.

Nodules located posterior to the angle of the mandible should be considered to be parotid tumors in their initial management. Although a nodule in this location can be an enlarged lymph node, it is more likely to be a tumor of the parotid gland, in our experience. Therefore, mere enucleation of such lesions under local anesthesia should be avoided. Adequate removal of parotid tumors in this posterior location requires general anesthesia and, at least, a superficial parotidectomy.

The clinical course of the various salivary gland tumors in children also appears to be similar to that for adults. Thus, long periods of follow-up are required before cure of certain lesions, such as mixed and mucoepidermoid tumors, is certain. Kauffman and Stout did not encounter a mixed tumor of a major salivary gland in a patient less than 7 years old; this conforms with our experience.[2] Mixed and mucoepidermoid tumors usually enlarge slowly.

Except for the problem of local recurrence and metastatic spread, postoperative complications in the children with major salivary gland lesions were minimal in the group of patients in this study. Two patients had transient facial weakness following superficial parotidectomy for mixed tumor, one of these patients also developing gustatory sweating (Frey Syndrome).

Of course, a variety of benign and malignant lesions, not represented in this study, can occur in the major salivary glands in both children and adults. Some of these have been noted in several reports which indicate their rare occurrence.[8-10] The parotid glands may be diffusely enlarged as a result of involvement by systemic disease such as sarcoidosis. A parotid tumor may be simulated by underlying mandibular tumors, primary or metastatic, which push the parotid anteriorly.

SUMMARY AND CONCLUSIONS

1. In an evaluation of 22 patients, who were 16 years of age or less at the time of recognition of tumors in their major salivary glands, the spectrum of the pathology of lesions, excluding acute inflammatory processes, corresponded to that for adults, except that hemangioendotheliomas and congenital angiomas predominated in infancy and early childhood.

2. Tumors of the major salivary glands require, in general, an initial wide excision by at least a superficial parotidectomy or excision of the submaxillary gland. Enucleation, or other inadequate surgical procedures, has resulted in the past in a high recurrence rate of salivary gland tumors in children. This was especially emphasized in the commonly occurring mixed and mucoepidermoid tumors. Thus, the surgical principles of management of salivary gland tumors in adults applies equally to children.

3. Chronic or recurrent sialadenitis, not responding to medical measures, occasionally requires operative treatment in children.

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An Unusual Case of Middle Ear Injury

BY JACK CAMPBELL, M.D.
BATTLE CREEK

A recent comprehensive article in the Laryngoscope, June 1968, by Hough and Stewart[2] indicates the infrequent recording of conductive lesions due to middle ear injuries. This article is chiefly devoted to those cases in which middle ear injuries are found associated with severe injuries where skull fractures are encountered, et cetera. Our report is of traumatic injury to the external auditory canal with middle ear injury.

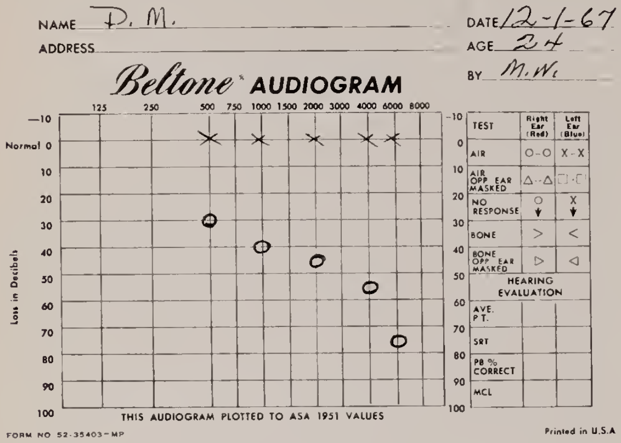
The patient was a white male, age 24, who was a repairman for the telephone company. On 11/30/67 he was admitted to the Out Patient Department of the hospital, roughly two hours after the following had taken place: at 11 a.m. he was disconnecting a telephone line at the side of a house and while reaching a twig of a tree around which he was working penetrated under his cap and into his ear canal. Immediately he sustained severe pain and severe vertigo. He fell to the ground and after the vertigo maintained itself, he managed to crawl to the company truck and use the mobile phone to call for medical aid. He had no severe bleeding at the time, complaining only that he had severe vertigo. He was unable to stand without putting his arms out from his sides to steady himself in space and, of course, he heard very poorly.

He was examined rather promptly in the Out Patient Department admitting room and was found to have a traumatic perforation of his right tympanic membrane after the twig had deflected from the anterior wall of the external auditory canal. Furthermore, with microscopy, it was noted that there was an incudo-stapedial dislocation.

Two days after his admission, because of the obvious involvement of his vestibule, secondary to his trauma, and when we were more reasonably certain that we had protected him from tetanus and infectious labyrinthitis, etc., he was taken to the operating room. Under local anesthesia a tympanomeatal flap was developed with some difficulty because of the trauma involving the external auditory canal. After reflecting this forward and controlling the bleeding with adrenalin tampons, the posterior canal wall was taken down in the usual manner and we were able to visualize the problem: he had dislocated both the incus and the stapes.[3] The incus was no longer in continuity with the stapes and the stapes was rotated 45 degrees toward the promontory and depressed into the vestibule slightly. The sacule did not appear to be injured from the trauma, however, following removal of the stapes.

It was my belief, at the time, that the incus was fractured and a stainless steel prosthesis gelfoam wire was placed from the long process to the oval window. It was difficult for us to identify the malleus handle adequately because of the traumatic condition of his tympanum and we were not as hopeful that a prosthetic device from the malleus to the oval window would work as well as one from the incus to the vestibule. The incus was so mobile, however, we were unable to use a stainless steel pre-formed gelfoam prosthesis, so an aluminum teflon piston was used, as this has a grasp application and we were able to tighten this over the neck of the incus and place it over a compressed gelfoam pad, maintaining the position of the incus in its normal position and place it over a compressed gelfoam pad covering the oval window, using a modification of a consistently effective procedure restoring the sound conduction to the oval window, as outlined by Dr. Howard House.

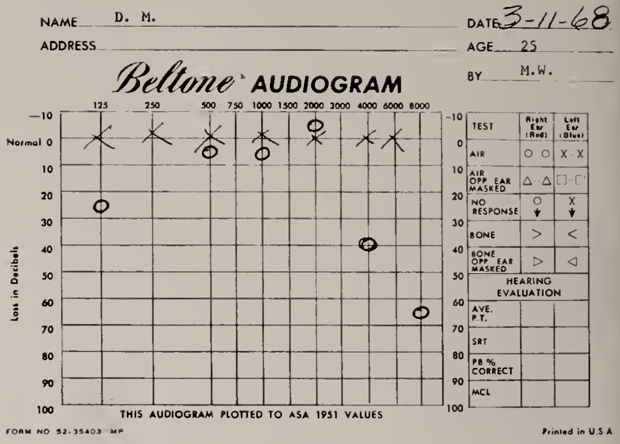
Following this procedure, we then anesthetized the pretragal area and the tragus was exposed and the upper half excised. The perichondrium was stripped from this. One-half of this was compressed, after thinning, and placed under the tympanic membrane, after we had first placed gelfoam soaked in Chloromycetin otic into the middle ear space. The tympanic defect seemed to be covered nicely this way and this same "slush" was then used as a retainer of the tympanomeatal flap, after it was reflected into its normal position. A mastoid dressing was applied and the procedure was terminated.



NAME D. M.
DATE 12-1-67
ADDRESS
AGE 24
BY M.W.

FIGURE 1

An audiogram done prior to his surgery (**Figure 1**) indicated a rather severe hearing impairment with evidence of probable injury to the sensorineural mechanism. Because of his hearing loss and because he had had previous audiometric evaluation at the University of Michigan, we obtained a copy of the work done there in June 1965. The final diagnosis of their department was chronic sinusitis and possible mild high tone sensorineural deafness. This then made us cognizant to the fact that he had perhaps had some pre-existing problem in his ear. However, after obtaining their records, we found that they were concerned with his left ear and his trauma was to his right ear. Thus, we were forced to conclude that he did not have a pre-existing sensorineural hearing loss to his injured ear.



NAME D. M.
DATE 3-11-68
ADDRESS
AGE 25
BY M.W.

FIGURE 2

An audiogram (**Figure 2**) three months after his surgery will indicate complete recovery through the speech range of his hearing loss. Moreover, it will be noted that he had some recovery in the area most concerned about in acoustic trauma, 4000 cycles, but still showed evidence of sensorineural damage.

The important features of the management of the case, of course, were that his vertigo was almost non-existent within three days after surgery and that he had an uneventful recovery with a non-infected middle ear cavity and labyrinth following surgery. Further, he had a salubrious response to his graft and prosthesis. The patient was returned to his normal occupation in a six week interval and as far as he is aware, his hearing is normal binaurally.

Summarily, a brief resume of the handling of traumatic ossicular[4] disruption and dislocation combined with tympanic perforation with present day microsurgery is presented.

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Acute Mumps Meningitis

BY CARLOS A. PHILIPPON, M.D., F.A.A.P.
ALMA

Acute mumps meningitis is a relatively common, benign and short lived complication of mumps virus infection. The condition should not be confused with mumps encephalitis which is more severe, carrying a 20% mortality and a higher incidence of neurologic sequelae (ataxia, hemiplegia, spastic triplegia, etc.).

The purpose of this report is to call attention to this entity that may go undiagnosed unless sought for.

MATERIAL

This small series consists of 8 cases of acute mumps meningitis (**Table 1**) drawn from a single Pediatric Practice and seen at Gratiot Community Hospital in Alma between the months of February and May of 1968.

There were 6 males and 2 females, in keeping with the reported preponderance of males over females at a ratio of 5:1. The age ranged from 4 to 12 years.

TABLE 1

Symptoms	**No. of Cases**
Headaches	8
Vomiting	8
Fever	8
Malaise	8
Stiffneck	8
Photophobia	7
Parotid Swelling	6
Dehydration	5
Convulsions	0

CLINICAL SYMPTOMS

All 8 cases had an abrupt onset of illness with fever, headaches and vomiting followed within 24 hours by mild stiffness of the neck and photophobia.

Signs of meningeal irritation were elicited in all on admission. The onset of CNS involvement followed the parotid swelling for 7 days in 3 cases, 2, 5 and 10 days in another 3. One never developed glandular swelling and in 1 case parotitis appeared on the right side 3 days after the CNS symptoms and on the left 3 days after the right.

LABORATORY FINDINGS

As can be seen in (**Table 2**) all 8 cases had spinal fluid pleocytosis ranging from 84 to 1450 with a lymphocytic preponderance in 6.

As expected Protein and Sugar were normal or slightly elevated and all cultures were negative. Case 3 is included even though the CSF was normal, because the patient had all the clinical features already described.

Table 3 depicts the results of the CBC's showing a tendency to a mild leukopenia, the lowest being Case VIII with 2800 cells. A polymorphonuclear leukocytosis on the peripheral smear is present in most cases.

Virus isolation was attempted in 3 cases by forwarding the CSF to the Bureau of Laboratories, Michigan Department of Health. All 3 cases were negative. This failure to isolate mumps virus may

TABLE 2

		Aspect	**T. Cells**	**WBC**	**RBC**	**Pol.**	**Lym.**	**Pr.**	**Sugar**	**Culture**
Case I	Initial	clear	220	220	0	213	7	29	87	neg.
	2 days	clear	526	526	0	285	141	25	95	neg.
Case II	initial	clear	84	84	0	6	78	37	78	neg.
Case III	"	clear	7	7	0	1	6	25	100	neg.
Case IV	"	sl. cloudy	1452	1452	0	0	1452	53	95	neg.
Case V	"	clear	403	403	0	0	403	37	90	neg.
Case VI	"	clear	1238	1205	33	0	1205	78	78	neg.
Case VII	"	clear	397	397	0	234	163	29	73	neg.
Case VIII	"	clear	628	628	0	214	414	70	73	neg.

cerebrospinal fluid results

TABLE 3

	Hemoglobin	WBC	Polys	Lymphs.	Eos.	Monoc.	Basoph.
Case I	15.2 gm%	15.100	89%	11%	—	—	—
Case II	13.6 "	6.400	52%	46%	2%	—	—
Case III	13.7 "	4.600	79%	21%	—	—	—
Case IV	14.4 "	6.100	31%	65%	1%	3%	—
Case V	11.4 "	5.800	78%	22%	—	—	—
Case VI	12.4 "	6.550	56%	44%	—	—	—
Case VII	12.8 "	10.700	80%	19%	—	1%	—
Case VIII	12.4 "	2.800	60%	37%	2%	1%	—

CBC results

have been due to our faulty handling of the specimens. Complement fixation titers were obtained in 2 cases, both with positive result thus confirming the clinical diagnosis. The test was crucial in Case I in whom parotid swelling never developed.

HOSPITAL COURSE AND TREATMENT

Clinical symptoms subsided within a week in all cases except one who remained febrile for 8 days.

Convulsions occurred in none nor were there any signs of neurologic sequelae at the time of discharge.

None of the cases had papilledema or evidence of increased intracranial pressure.

The treatment consisted of symptomatic and supportive measures. Analgesics and antipyretics were used as needed and, only occasionally, mild sedation with a short acting barbiturate.

All cases obtained temporary relief from headaches at the time of the lumbar puncture.

Five children required intravenous fluids to correct a mild to moderate dehydration and persistent vomiting.

COMMENTS AND DISCUSSION

Acute mumps meningitis is a complication of the mumps (myxovirus) infection that follows a rather typical clinical pattern of sudden onset of illness with fever, headaches, vomiting, variable degree of stiffness of the neck and signs of meningeal irritation on physical examination.

It usually appears 7-10 days after the glandular involvement although it may precede, manifest during or without any evidence of parotitis.

The absence of cerebral symptoms points to a pure meningeal involvement.

The cerebrospinal fluid shows pleocytosis with normal or elevated Sugar and Protein. These findings alone are, of course, not diagnostic since aseptic meningitis of other etiology will present the same changes.

It is estimated that between 35 and 65% of cases of mumps will show CSF pleocytosis if tested routinely so that this finding becomes even less specific.

The presence of the typical clinical picture during an epidemic in the community coupled with glandular involvement warrants the diagnosis of acute mumps meningitis.

In those instances where one or more criteria are missing confirmation must be obtained by virus isolation or serologically with complement fixation titers.

A leukocytosis with neutrophilia in the peripheral smear is described as present during the initial, acute stage of the disease. Our cases had a tendency to a mild leukopenia that was pronounced in one instance. There was relative neutrophilia in most. The true incidence of this complication is difficult to ascertain because of the varying reports including those from the Communicable Diseases Center of the U.S. Public Health Service. When the cases are reported from the local level they are included under the heading of "Encephalitis of a post-infectious nature" and I imagine that by so reporting we have added 8 more cases of "Encephalitis" to the National Registry.

Mumps meningitis is, nevertheless a common condition. Among 511 cases of acute CNS diseases of viral etiology reviewed by Lennette and coworkers they found 42 cases or 8% to be due to mumps. At the local level, according to the Monthly Surveillance Report by the Michigan Department of Public Health (*Michigan Medicine* —906—July 1968) there were 11,808 cases of mumps in the first 5 months of 1968 as against 10,512 for the same period in 1967.

Forty-seven cases of Encephalitis are listed but without giving the etiology.

SUMMARY

Thus, to conclude: a youngster who, during an epidemic of mumps has been exposed to, or has mumps parotitis and develops a sudden illness characterized by fever, headaches, vomiting and stiffness of the neck very likely suffers from mumps meningitis and deserves a lumbar puncture. This latter procedure will accomplish threefold:

1. will rule out a purulent or bacterial meningitis
2. will confirm the clinical diagnosis and
3. will temporarily relieve the patient's cephalalgia.

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APPENDIX

REPRESENTATIVE CASES

CASE 1 is an 8-yr.-old Caucasian male who was in his usual state of health until 24 hours prior to admission when he suddenly developed fever. Within the next 12 hours he complained of severe headaches and vomited once.

When examined on the day of admission he was alert with no cloudiness of his cerebral faculties. The temperature was 102 rectally. There was stiffness of the neck but without rigidity. Brudzinski, Kernig and "tripod" signs were present. The optic fundi were normal. A lumbar puncture disclosed clear CSF with 220 white cells of which 213 were neutrophils and 7 lymphocytes.

A second spinal fluid 2 days later again showed pleocytosis of 526 with 285 polys and 141 lymphs. Protein and Sugar were normal. The youngster remained febrile, complained of severe headaches and photophobia but mentation was normal at all times.

A complement fixation titer for mumps virus in serum showed an acute phase sample of 1:8 and a fourfold rise to 1:32 in 3 weeks. The patient recovered uneventfully and without sequelae.

COMMENT: this interesting case began with a picture of aseptic meningitis of viral etiology, the ultimate diagnosis unfolding only when the serology revealed the presence of rising titers for mumps.

CASE VII: This 4-yr.-old Mexican-American male youngster was well until the night prior to admission when he suddenly developed fever, headaches and vomiting. By the next day he continued ill having now complained of photophobia.

He was known to have been exposed to mumps in the previous 2 weeks by two siblings.

Initial examination revealed fever of 102.2, lethargy but with normal mental faculties. Signs of meningeal irritation were elicited: Brudzinski, Kernig and nuccal stiffness.

The parotid regions were normal with no evidence of swelling or tenderness.

By lumbar puncture clear CSF was withdrawn containing 397 cells of which 234 were neutrophils and 163 lymphocytes.

Sugar 73 mg. % and Protein 29 mg. %. The hemoglobin was normal and the WBC showed 10,700 cells with 80% neutrophils and 19% lymphocytes, 1% monocytes.

Three days after admission and with the above clinical picture only slightly improved he developed parotid swelling and tenderness on the right, followed, three days later, by left sided parotitis.

Acute phase complement fixation titer of 1:8 with a convalescent titer of 1:128 were obtained.

He recovered without sequelae after 8 days of low grade fever, malaise and intermittent headaches.

COMMENT: This youngster developed the complication before the appearance of the glandular involvement thus indicating the wide spread distribution of the virus before localizing the disease to the parotid glands.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

MONTHLY SURVEILLANCE REPORT CASES OF CERTAIN DISEASES REPORTED TO THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH FOR THE FIVE-WEEK PERIOD ENDING NOVEMBER 2, 1968

	1968 This 5-Week Period	1967 Same 5-Week Period	1968 Total To Above Date	1967 Total Same Date
Measles	21	31	296	971
Whooping Cough	21	90	378	905
Diphtheria	0	0	0	1
Mumps	294	901	13545	14103
Scarlet Fever & Strep Sore Throat	713	860	8365	11048
Tetanus	1	1	3	3
Poliomyelitis (Paralytic)	2	0	2	3
Hepatitis	283	194	1900	1658
Salmonellosis (Other than S. typhi)	56	91	545	505
Typhoid Fever (S. typhi)	0	1	0	8
Shigellosis	50	56	258	373
Aseptic Meningitis	50	22	234	70
Encephalitis	20	11	89	97
Meningococcic Meningitis	4	6	78	64
Influenzal Meningitis	10	7	52	50
Tuberculosis	256	306	2365	2512
Syphilis	545	588	4593	4790
Gonorrhea	1891	1645	15275	14383

Information can be supplied by the local health department on the local incidence of disease.

R. Gerald Rice, M.D., Director
Michigan Department of Public Health

Xanthogranulomatous Pyelonephritis

ABSTRACT: A case of xanthogranulomatous pyelonephritis in a fifty-five year old female is presented to document the rapid progression of this disease during a forty-five month period. This destructive inflammatory process is usually unilateral and associated with a Proteus infection. At times the gross and radiologic picture may resemble a renal tumor; furthermore, the microscopic appearance of the large vacuolated foam cells has been confused with the clear cells of hypernephroma. Treatment usually consists of nephrectomy of the affected side.

BY MARK C. MC QUIGGAN, M.D., F.A.C.S.
HENRY Y. LIU, M.D., F.A.S.C.P.
BOTH OF SOUTHFIELD

Xanthogranulomatous pyelonephritis is a destructive disease of the kidney which may mimic renal carcinoma in its pyelographic as well as its gross and microscopic appearance.[1, 2, 3] While the end result of this disease is usually a functionless kidney the rate of progression of the disease has not been determined. This case is being presented to document the possible rapid progression of this disease. Minimal caliectasis in the upper pole of the kidney was demonstrated on a pyelogram taken forty-five months prior to admission. These minimal inflammatory changes progressed rapidly to total destruction of the kidney.

CASE REPORT

P.T. (No. 090047) is a 55-year-old Negro female who was admitted to Providence Hospital on December 20, 1967 with a history of a urinary tract infection which did not respond to antibiotic therapy. An intravenous pyelogram on December 11, 1967 demonstrated non-visualization of the left kidney and minimal caliectasis in the right upper pole.

In 1964 this patient underwent urologic investigation for a similar problem. An intravenous pyelogram obtained on March 16, 1964 demonstrated minimal caliectasis on the left **(Figure 1)**. At cystoscopy, findings compatible with chronic cystitis were noted. At this time the patient responded well to antibiotics and remained asymptomatic until about six months prior to admission when she began to experience bladder irritative symptoms. She did not seek medical advice until one month prior to admission.

A blood pressure of 140/90 was noted. The rest of the physical examination was within normal limits.

The hemogram was normal, the blood urea nitrogen was 22 mg. per 100 ml. and the fasting blood sugar was 105 mg. per 100 ml. on admission. Marked pyuria and bacteruria without albuminuria

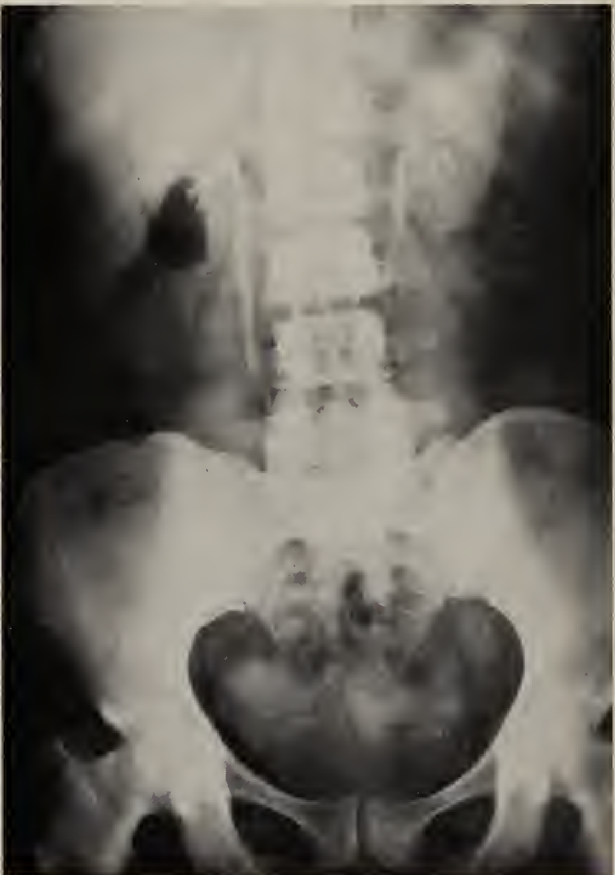

Figure 1. Minimal caliectasis is noted in the upper pole of the left kidney on the intravenous pyelogram taken forty-five months prior to admission.

The authors are both associated with Providence Hospital, 16001 W. Nine Mile, Southfield, Michigan; Doctor McQuiggan with the Department of Urology, and Doctor Liu with the Department of Pathology.

were noted on the urinalysis. Urine culture from the bladder and left kidney grew out Proteus. The 24 hour urine for acid fast bacteria and the tuberculin skin test were negative. Urine cytology was negative. Postoperative cholesterol was 209 mg. per 100 ml. and total serum lipid was 2638 mg. per 100 ml.

Since this patient presented with persistent urinary tract infection and non-visualization of the left kidney, retrograde studies were planned. At cystoscopy on December 21, 1967 some inflammatory changes on the floor of the bladder were seen. When the ureteral catheter was passed on the left side a thick purulent drainage was obtained. The retrograde pyelogram (**Figure 2**) demonstrated far advanced destructive inflammatory changes of the entire kidney with ragged edges and dilatation of the entire renal pelvis and ureter. The density of the third lumbar vertebrae was increased suggesting metastatic disease or Paget's disease of bone.

Since metastatic neoplasm was suspected as a cause of the vertebral lesion, a thorough search for a primary was undertaken. Upper gastrointestinal examination, barium enema, examination of the breasts and pelvic examination failed to demonstrate any neoplasms. The alkaline phosphatase was not elevated. Since none of these studies suggested neoplasm the diagnosis of Paget's disease of bone was made.

Because the left kidney was almost completely destroyed, funtionless, and involved with a severe purulent inflammatory process, a left nephrectomy was advised. On December 27, 1967 the left kidney was approached through the twelfth rib bed and left nephrectomy was performed. Postoperative course was uneventful. The urine culture was negative one week postoperatively. The patient was discharged on an ascorbic acid preparation and nitrofurantoin 100 mg. four times a day.

The kidney weighed 180 mg. Its capsule was thickened, edematous and firmly adherent to the renal cortex. On the cut surface (**Figure 3**) the renal calyces and pelvis showed marked dilatation and tissue destruction. The inner surface appeared ragged and hemorrhagic. In the adjacent renal tissue, numerous small bright yellow nodules and fibrotic areas were present. Microscopically, the wall of renal calyces and pelvis, and part of renal medulla were replaced by a thick band of granulation tissue which was characterized by numerous congested capillaries and rich cellular infiltrate of an inflammatory nature. Toward the calyceal surface, hemorrhage and tissue necrosis were marked. In the cellular infiltrate, plasma cells predominated. However, the most striking feature was the presence of the large mononuclear xanthomatous cells, with a vacuolated and finely reticular

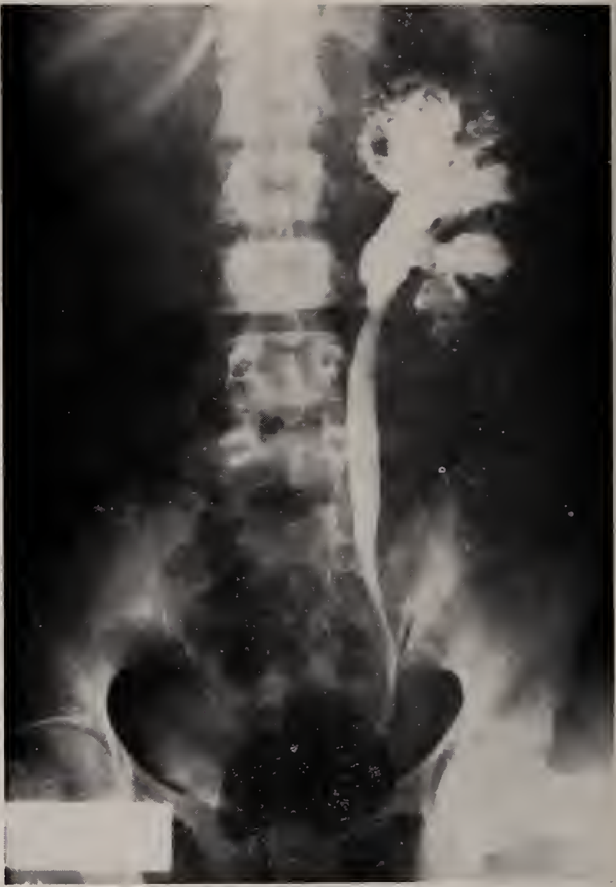

Figure 2. The preoperative left retrograde pyelogram demonstrates marked destruction of the entire kidney with dilatation of the entire ureter.

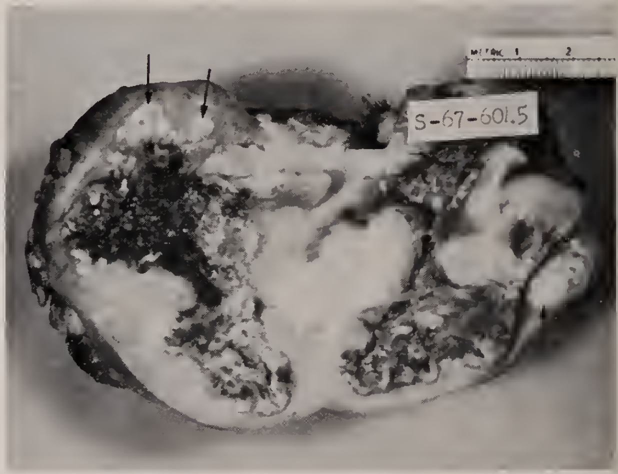

Figure 3. Cut surface of the bisected kidney showing marked destruction of renal tissue along the dilated calyces. Arrows indicate prominent yellow nodules of xanthomatous tissue.

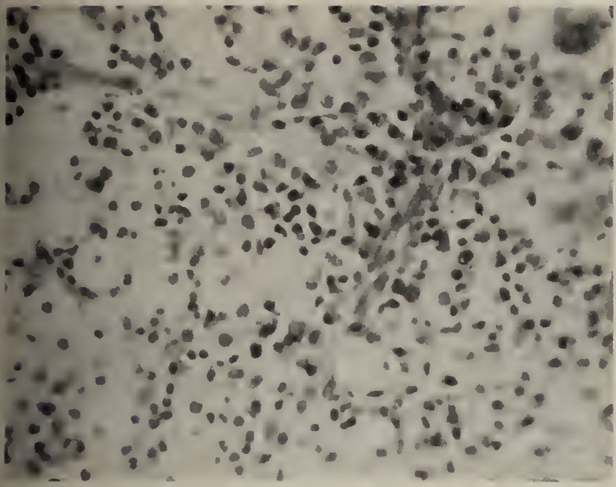

Figure 4. High magnification of an inflamed area. Note the intimate mixture of xanthomatous cells and other inflammatory elements. A multinucleated giant cell is in upper right (H and E stain, 450 X).

cytoplasm (**Figure 4**). Their nuclei were relatively small but often showed a prominent nucleolus. These xanthomatous cells were seen throughout the granulation tissue. Large aggregates of them corresponded to the yellow nodules seen grossly. Multinucleated giant cells with similar nuclear structures but with denser and more eosinophilic cytoplasm were frequently seen side by side with the xanthomatous cells. The renal cortical tissue displayed marked periglomerular and interstitial fibrosis with loss of parenchymal elements, leukocytic infiltration and exudates in the tubular lumen. The pathological diagnosis was xanthogranulomatous pyelonephritis.

Follow up lipid studies were obtained on June 17, 1968. They were as follows: Total cholesterol 289 mg. per 100 ml., total lipid 1000 mg. per 100 ml., triglycerides 67 mg. per 100 ml., Phospholipid 8.5 mg. per 100 ml. The lipoprotein electrophoretic pattern was normal with a 35 percent alpha fraction and a 65 percent beta fraction.

DISCUSSION

INCIDENCE

Xanthogranulomatous pyelonephritis is an unusual disease which is rarely bilateral.[1,2] The youngest reported case was in a nine year old girl[5] and the oldest reported case was in an eighty-two year old man.[6] The disease occurs most commonly in the fifth decade. The sex distribution varies with the series reported.[5, 6]

ETIOLOGY

At the present time it is not clear whether this xanthomatous process represents a localized response to infection or a generalized lipid disorder. Saeed and Fine in a report of four cases[7] incriminate a metabolic defect of lipid metabolism because of the absence of lipid macrophages in other types of pyelonephritis and the variable bacterial flora seen in xanthogranulomatous pyelonephritis. However, this was a speculative assumption since the serum lipid fractions were not studied. In our case a complete lipid profile was obtained (see case report). The total serum lipid and the total cholesterol were slightly elevated, but the phospholipid, the triglycerides and the lipoprotein electrophoretic pattern were within normal limits. This suggests that this disease is not a generalized lipid disorder but rather represents a peculiar localized reaction to infection in which phagocytosis of a fatty substance takes place. Diabetes mellitus is not associated with xanthogranulomatous pyelonephritis as it is with some of the other xanthomatous diseases.

All cases of this disease have severe bacterial infections of the kidney and the majority of these infections involve a Proteus organism. Renal calculi often accompany infections caused by urea splitting organisms such as Proteus, so their presence in xanthogranulomatous pyelonephritis is not surprising. Many of the cases reported are associated with obstructive uropathy. While this may initiate the infection it would not be a specific cause of this disease.

CLINICAL COURSE

Typically the patient with xanthogranulomatous pyelonephritis presents with a history of recurrent urinary tract infection, Proteus being the most common organism involved. Often the urine cannot be cleared with antibiotic therapy. Symptoms include those of bladder irritation and hematuria as well as generalized sepsis with chills and fever. Flank pain is common. Occasionally this disease presents as an abdominal mass.[8] The disease process is destructive and usually the involved kidney is completely functionless. Fortunately the disease is almost always unilateral and therefore nephrectomy provides a complete cure. The natural course of the disease has not been previously documented and this case is unique in this respect. Minimal pyelonephritic changes progressed to complete destruction of the kidney within a four year period.

DIAGNOSIS

This disease is unique in that it may mimic renal neoplasm radiographically, grossly and even microscopically. The affected side is usually not visualized by intravenous pyelography because of the lack of function. The retrograde pyelogram may demonstrate a space occupying lesion as seen in a hypernephroma. Or it may present as a diffuse inflammatory process involving the entire kidney with or without hydronephrosis and hydroureter, as is seen in renal tuberculosis or some types of far advanced obstructive uropathy. Angiography, if done, usually demonstrates a decreased vascular pattern which may be of some help in the differential diagnosis.

At operation the diagnosis is not always obvious. At times the diseased kidney is adherent to adjacent structures as seen in neoplasm and unnecessarily radical operations have been performed. In one case, what was thought to be an inoperable hypernephroma was biopsied and the microscopic diagnosis of clear cell hypernephroma was made. Radiation therapy was given. When the patient was alive nine years after the initial diagnosis the slides were reviewed and the error was discovered.[8] The lesion which was thought to be hypernephroma was indeed xanthogranulomatous pyelonephritis.

PATHOLOGY

The definitive diagnosis of xanthogranulomatous pyelonephritis can be made only by histologic examination of the diseased kidney. Grossly the xanthomatous area is bright yellow and if localized may appear neoplastic. However, if diffuse it resembles a severe pyelonephritis with or without pyonephrosis and small renal abscesses. Microscopically an intimate admixture of large, vacuolated, mononuclear xanthomatous cells and abundant inflammatory infiltrate is seen in xanthogranulomatous pyelonephritis. In renal cell carcinoma of the clear cell type the individual cells may resemble the xanthomatous cells, but the neoplastic cells are arranged in an organoid pattern with less inflammatory infiltrate. The PAS positive material is usually negative after diastase treatment in renal cell carcinoma but remains positive in xanthogranulomatous pyelonephritis. Fat stains demonstrate abundant lipids in xanthoma cells. Confusion in diagnosis is usually encountered when only a limited portion of the kidney is available.

TREATMENT

Since the disease process is usually so far advanced when the diagnosis is made, antibiotic therapy has little value in the primary treatment of xanthogranulomatous pyelonephritis. Fortunately the disease is usually unilateral and nephrectomy provides a complete cure. In the few cases in which pyelonephritis has been noted in the contralateral kidney an attempt should be made to sterilize the urine and keep the kidney free of calculi.[6] In our case minimal caliectasis was noted in the remaining kidney and the patient was placed on nitrofurantoin indefinitely. Ascorbic acid was added to the regimen to acidify the urine and thereby potentiate its effect.[4] The urine has remained sterile to date.

SUMMARY

A case of xanthogranulomatous pyelonephritis in a fifty-five year old female is presented. The case is unique because the progression of the disease from minimal caliectasis to complete renal destruction during a four year period is documented. An essentially normal serum lipid profile suggests that this disease represents an unusual reaction to infection rather than a generalized disease.

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Physicians - Population Ratios in Michigan - 1968

County	Population	M.D.'s	D.O.'s	People per Physician
Alcona	6,000	0	0	—
Alger	8,400	5	0	1,680
Allegan	56,500	27	2	1,948
Alpena	30,000	28	1	1,035
Antrim	9,000	3	5	1,125
Arenac	9,000	3	1	2,250
Baraga	7,200	4	0	1,800
Barry	30,000	15	4	1,579
Bay	107,000	91	28	899
Benzie	7,800	3	2	1,560
Berrien	161,000	112	25	1,175
Branch	34,000	29	4	1,030
Calhoun	151,000	146	36	829
Cass	36,500	10	3	2,830
Charlevoix	15,500	7	1	1,938
Cheboygan	14,000	8	0	1,750
Chippewa	35,000	20	3	1,521
Clare	12,000	6	6	1,000
Clinton	43,000	11	6	2,529
Crawford	5,200	8	1	578
Delta	34,000	23	0	1,478
Dickinson	23,600	28	0	843
Eaton	55,000	22	9	1,774
Emmet	16,500	42	1	384
Genesee	435,000	331	154	895
Gladwin	10,000	4	4	1,250
Gogebic	20,000	13	1	1,429
Grand Traverse	36,000	82	18	360
Gratiot	38,000	22	13	1,086
Hillsdale	34,000	17	6	1,478
Houghton	34,000	26	0	1,308
Huron	34,000	20	5	1,360
Ingham	265,000	296	63	710
Ionia	44,000	22	11	1,333
Iosco	20,000	5	1	3,333
Iron	15,000	11	2	1,154
Isabella	36,000	29	7	1,000
Jackson	135,000	110	22	1,022
Kalamazoo	190,000	242	13	745
Kalkaska	4,500	3	0	1,500
Kent	385,000	440	84	735
Lake	4,500	3	1	1,125
Lapeer	46,000	24	19	1,070
Leelanau	9,500	1	1	4,750
Lenawee	78,000	60	6	1,181
Livingston	42,000	27	9	1,166
Luce	7,500	14	0	536
Mackinac	10,800	6	3	1,200
Macomb	575,000	238	161	1,441
Manistee	19,200	15	6	914
Marquette	63,500	56	0	1,134
Mason	21,500	17	1	1,194
Mecosta	21,500	13	6	1,132
Menominee	25,000	10	0	2,500
Midland	55,000	60	2	887
Missaukee	6,000	2	0	3,000
Monroe	110,000	43	17	1,833
Montcalm	37,500	19	25	852
Montmorency	4,200	0	1	4,200
Muskegon	150,000	122	45	898
Newaygo	25,000	13	1	1,786
Oakland	900,000	992	300	696
Oceana	16,000	6	1	2,286
Ogemaw	9,000	8	3	818
Ontonagon	11,000	4	0	2,750
Osceola	13,800	4	3	1,971
Oscoda	3,500	1	1	1,750
Otsego	8,500	7	0	1,214
Ottawa	106,000	75	9	1,262
Presque Isle	12,500	3	0	4,167
Roscommon	7,300	6	4	730
Saginaw	208,000	175	62	878
St. Clair	110,000	80	10	1,222
St. Joseph	43,000	28	5	1,303
Sanilac	34,000	17	8	1,360
Schoolcraft	8,000	6	0	1,333
Shiawassee	59,000	32	7	1,512
Tuscola	45,000	17	10	1,667
Van Buren	51,000	27	2	1,762
Washtenaw	210,000	756	17	271
Wayne	2,670,000	3,049	651	721
Wexford	18,000	18	4	818

These figures from Michigan Health Council

MAP . . . A Decade of Accomplishment

What is?

What if?

Together those two thoughts form a synthesis for action.

As questions they demand answers. As musings they spark imaginative hopes. As challenges they issue a clarion call to accomplishment. They resulted in the organization of MAP ten years ago.

In 1957 the medical profession said, by way of a survey conducted by the MSMS, that it believed coordinated activity of the professions was overdue.

THE SURVEY SPELLED out the major needs — the "what is" — and the favored procedures for meeting those needs in an organization devoted to the protection and promotion of professionalism — the "what ifs."

Hugh W. Brenneman, then Public Relations Counsel of MSMS and adviser to a number of other state professional associations, was authorized to proceed with the organization of an association of the professions and money was advanced to hire staff assistance and pay for initial meetings and mailings.

MAP
CONGRESS OF THE PROFESSIONS

Coincidental with this action by the medical society, other professional societies were alerted to the potential of united action by the leading professions in areas of education, legislation, professional and public relations, and business services.

Almost simultaneously the boards of directors of the state professional societies passed resolutions calling for the establishment of a permanent organization with individual memberships as well as state association representation which could become financially viable and independent of any single group.

Their thinking was summed up in the expression of George W. Slagle, M.D., the then President of the MSMS.

"The power of the professions, as organizations, to serve the public good is not being used effectively because it is not being exerted in unison," Dr. Slagle said. It is ironic that at a time in our history when the nation is crying for brain-power, the most learned group of all, the professions, are being by-passed when decisions affecting their future are being made."

His successor, G. B. Saltonstall, M.D., supplemented his thought with: "Industry and labor are represented at the bargaining tables of the nation by single, powerful voices, backed by separate organizations which represent segments of interest. Legislators consult — and listen to — the wishes and demands of these highly organized groups (industry - labor). Their opinions are sought on almost all matters of legislation. By contrast, the professions are rarely considered, much less consulted, except in those instances when the matter directly affects technical subjects within the purview of one particular profession."

PEOPLE AND GROUPS at interest, but outside of the professional policy-making boards, were also consulted. Lester P. Dodd, J.D., Detroit attorney, a Past President of the State Bar and Legal Counsel of the MSMS, drafted bylaws. Dr. Marvin Niehuss, Vice President and Dean of Faculty of the University of Michigan lent support and advice. Congressman Gerald R. Ford, Jr., encouraged the development, various association executives and businessmen indicated interest and Pat Loomis as the sole staff assistant worked overtime.

Leaders of the five Charter professions met and agreed to form an association so that all professions might work together for their mutual benefit. Delegates appointed by the Board of Directors of the individual state professional societies worked out the organizational details, by-laws, administrative lines, membership qualifications, etc. The state professional societies represented at these meetings included the Michigan Society of Architects, the Michigan Society of Professional Engineers, the Michigan State Dental Association, the Michigan State Medical Society and the State Bar of Michigan.

The final organizational meeting, following approval in principle of a projected set of by-laws by the state professional societies, was held on November 23, 1958, in the new board room of the Michigan Road Builders Association in Lansing.

Bylaws were adopted, a board of directors and officers were elected and authorization given for incorporation papers to be filed.

The Founding Board members were as follows:

William M. LeFevre, M.D., President
Floyd D. Ostrander, D.D.S., Vice President
Elmer J. Manson, A.I.A., Secretary
Frederick Von Voigtlander, P.E., Treasurer
Hugh W. Brenneman, Executive Director
John G. Nolen, D.D.S.
G. B. Saltonstall, M.D.
N. O. Saulter, P.E.

THE MICHIGAN ASSOCIATION of the Professions was officially incorporated on December, 1, 1958.

Growth was inevitable. Individual membership climbed quickly — first one, then two, then three thousand; the number stabilized at 3,000. State organization membership applications were received and after studied deliberations, new professions were added — certified public accountancy, veterinary medicine, pharmacy and education. Approximately 100,000 professional people are members of MAP state organizations. Still other professions are being considered.

Other states heard the story, first New York, then North Carolina, Illinois, Virginia, Wisconsin, Pennsylvania followed the MAP pattern. Other states, Iowa, Nevada, Hawaii, Indiana, Florida, Texas, Louisiana, etc. are thinking, talking, evaluating, meeting — in order that they, too, can follow suit.

MAP is governed by a Board of Directors. On that Board recognition rather than control is accorded those professions having larger numbers of individual members. MAP by-laws provide that the Board of Directors of each State Organization Member designate two of its members, who are also members of MAP, to serve as Directors on the MAP Board. In addition to those thus provided, an equal number of Directors are elected at the MAP Annual Meeting from its individual membership. Of these not more than three, nor fewer than one, can be members of any one of the professions.

The purpose of MAP is "to devise ways and means of better utilizing the professional heritage of knowledge and skill for the benefit of society, and to create relations between the professions

Officials of MSMS who met with leaders of other professions to discuss organization plans for MAP were, left to right, G. B. Saltonstall, M.D., Charlevoix; George W. Slagle, M.D., Battle Creek; and William M. LeFevre, M.D., Muskegon.

MAP — A DECADE OF ACCOMPLISHMENT . . . CONTINUED

looking toward that end." MAP was created to provide the organizational machinery whereby the combined strength and counsel of all professions could be utilized for the advancement of professional ideals and the promotion of professional welfare. It is directed toward strengthening the traditional rights and privileges of each profession and, at the same time assisting the professions to better serve the people.

MAP-TYPE ORGANIZATIONS are designed to protect and promote professionalism. They do this via action *against* legislation which would permit third party control from whatever source — labor, business, government, farming or industry — over the professions. They *support* legislation which serves to encourage private practice and maintain the professional attributes of professional persons in employed practice. The *Legislative Report,* containing information on all bills of interest to the MAP professions is distributed weekly to all members wishing it. An annual trip to Washington keeps MAP in close contact with Michigan Congressmen.

Leader

Brink

Brenneman

LEADER — Luther R. Leader, M.D., Royal Oak, has served as a member of the MAP Board for four terms and has received the MAP Booster Award in 1963. Doctor Leader, a past president of MSMS, is now secretary of the State Board of Registration in Medicine.

BRINK — J. Russell Brink, M.D., Grand Rapids, is a member of the MAP Board of Directors, second term, and has been active in organizing the American Association of the Professions.

BRENNEMAN — Hugh W. Brenneman, executive director of MSMS and MAP, spearheaded the organization of the professional group and has served since its founding as its executive.

MAP Education Committees stimulate student interest in professional careers as well as advise secondary schools on curricula development.

Use is made of all communication media to tell the public why professional people do what they do in the way that they do it and why that way is in the public interest. Over a period of nine consecutive years, MAP has produced more than 500 quarter and half-hour telecasts over major commercial TV stations on prime time.

MAP activities in communication develop understandings and knowledge about the professions among the several professions by way of interprofessional meetings (the annual one is called the Congress of the Professions) and by MONITOR, The Journal of the Professions.

Business services designed to aid individual professional people to obtain savings through group purchasing, such as Group Term Accidental Death, Life, and High Level Life Insurance, Professional Liability Insurance can be maintained when several professions are together which many individual professions or professional persons could not otherwise obtain. The MAP Pension Plan and Trust, the first plan in the nation to qualify under the Keogh Act, has since been updated and stands today as a model plan in the nation.

MAP and its emerging national body, the American Association of the Professions, represent the professional segment of society to balance representation of other segments of society represented by such organizations as NAM for industry, US Chamber of Commerce for business, AFL-CIO for labor, Farm Bureau for farming.

Is it not necessary that one organization be able to present basic thinking of the professional segment of society as these organizations do for their segments? Otherwise how are the wishes of the professions as minority groups going to be put forward?

THE AMERICAN ASSOCIATION of the Professions has been formed with the following purposes:

1. The encouragement of participation, throughout the United States, of all the professions in programs having for their objectives the advancement of professional ideals and professional welfare.

2. The promotion of better understanding between and among the several professions.

3. The promotion of a free and cordial interchange of opinion and information among its

MAP'S FOUNDING BOARD — These men comprised the first Board. Seated left to right are F. Von Voigtlander, P.E., Ann Arbor; William M. LeFevre, M.D., Muskegon; F. D. Ostrander, D.D.S., Ann Arbor; Elmer J. Manson, A.I.A., Lansing. Standing left to right are N. O. Saulter, P.E., Detroit; G. B. Saltonstall, M.D., Charlevoix; John G. Nolen, D.D.S., Lansing, Hugh W. Brenneman, Executive Director.

members on subjects of mutual or common professional interest.

4. The promotion, upon a national basis, of closer contact between and among the leaders of the learned professions.

5. The fostering, throughout the several states, of ever higher standards of professional ethics and conduct.

6. The promotion of programs and measures designed to protect the public and the professions against encroachments on professional practice by those not qualified.

7. The promotion of programs designed to offer professional and pre-professional students more adequate preparation for professional life.

8. The promotion of programs and measures designed to assist young professionals in meeting the problems of their respective professions.

9. The stimulation and fostering of leadership by the professions in public service activities on community, state and national levels.

FEW PROFESSIONAL PEOPLE can obtain more from any organization, other than their own primary professional society, than they can from MAP. Michigan is proud to be the front runner in this vital movement.

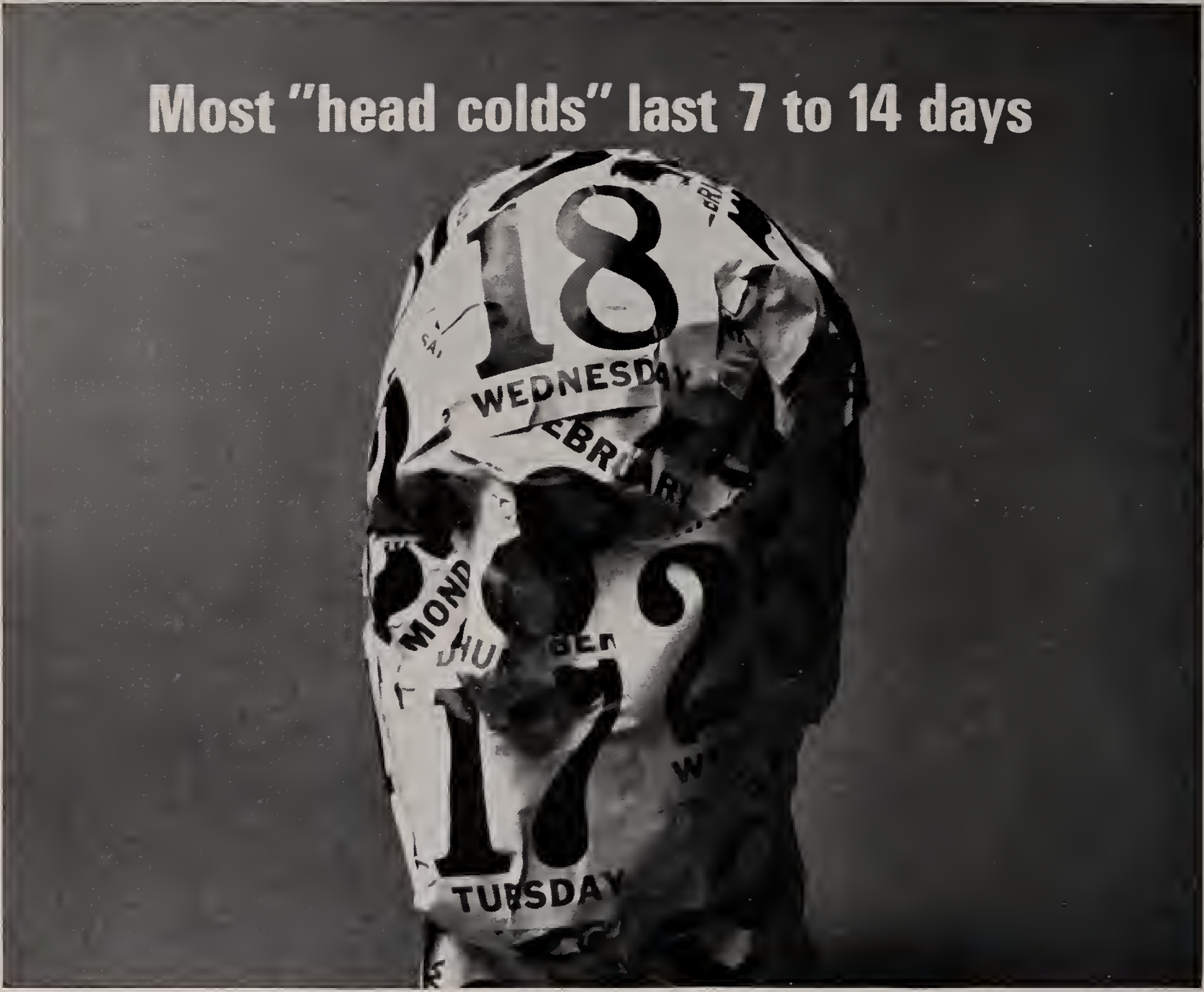
MAP has placed the professions "in the mainstream" of community and state-wide planning by working officially with civic groups in such activities as Michigan Week, Community Health Week and its own Professional Week which has been proclaimed for eight successive years by Michigan's governors.

If an organization is known by the "company it keeps" MAP must certainly rank at the top. Among those receiving its highest Awards were such leaders as famous architect Minoru Yamasaki (1963), Chief Justice John R. Dethmers (1964), State Building Director Adrian N. Langius (1965), Explorer Talbert Abrams (1966), Sculptor Marshall Fredericks (1967), and Dental Leader Dr. John G. Nolen (1968) — all of whom received the MAP Distinguished Award for Professional Excellence.

Outstanding Service Awardees, named for their contributions to the professions, were: Lester P. Dodd (1963), Hugh W. Brenneman (1964), Gerald R. Ford, Jr. (1965), Emory W. Morris (1966), Harlan Hatcher (1967), Harold F. Gross (1968).

BEGINNING DECEMBER 1, 1968, MAP will celebrate its 10th Anniversary. Many major activities are being planned, highlighted by a trip to Spain on February 8th and the final formal structuring of the American Association of the Professions.

MAP enters its second decade with a proud record of accomplishment, successfully organized and financed. At one of the early meetings, following the successful organization of MAP, Hugh Brenneman was officially declared to be Founder of the association and a motion of thanks to him was passed. Noting a moist eye, President LeFevre said to him: "This means a lot to you doesn't it?" The reply: "Yes. And I hope it means a lot to the professional people of Michigan."


Most "head colds" last 7 to 14 days
18
WEDNESDA
MOND
17
TUESDA

In the meantime... Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

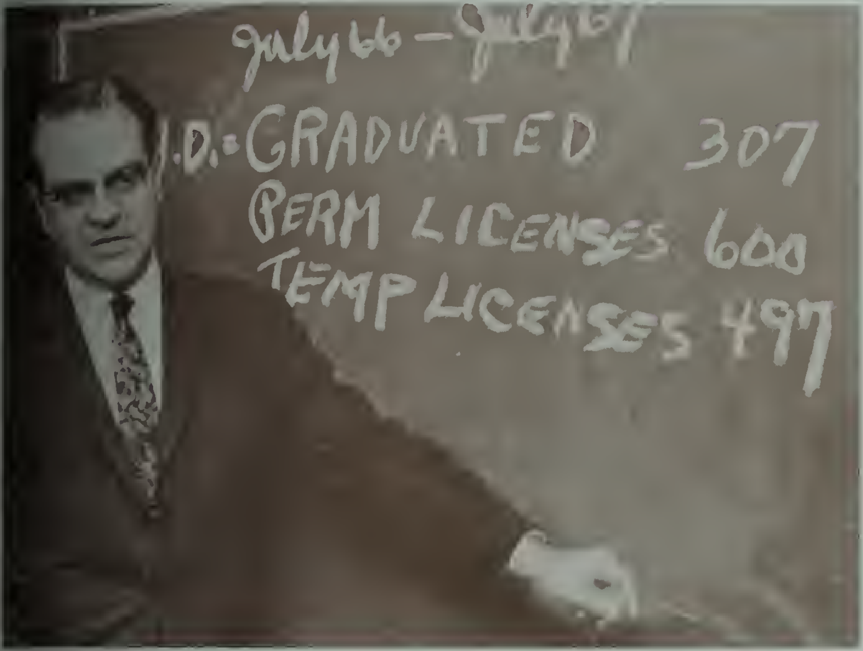
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.
Spansule® capsules brand of sustained release capsules

SK&F Smith Kline & French Laboratories

MSMS Manpower Plea Picks Up Speed



MSMS Council Chairman Ross V. Taylor, M.D., at a news conference in Jackson stressed that Michigan graduates about 300 doctors each year and licenses 1,000-1,100 physicians each year as a debtor state. (Jackson Citizen-Patriot Photo)

Co-Chairmen Robert J. Mason, M.D., left, MSMS President-Elect, and Warren Huff, outstanding Michigan educator and civic leader, spoke at the MSMS Medical Manpower Conference at Saginaw November 21 to 75 physicians and decision-makers from central Michigan and Thumb area.

All across Michigan the MSMS appeal that more physicians must be trained in Michigan is getting enthusiastic support from businessmen, civic leaders, industrialists, labor officials, educators, professional men, and the mass media.

The challenge that MSMS step up its efforts to stress the need for more medical schools was adopted by the 1968 MSMS House of Delegates. The organizational meeting for the Michigan Citizens Committee on Medical Education was organized in Detroit October 16, followed by a Michigan Conference on Medical Manpower at Battle Creek October 23. The MSMS Council outlined both immediate and long-range recommendations November 6 in a letter to the State Board of Education.

The first MSMS-sponsored regional conference, in connection with county society leadership workshops, was held in Grand Rapids November 14, and the next in Saginaw, November 28. The third is scheduled for the Metropolitan area December 12.

TV and radio stations have told the stories and articles have appeared in newspapers in Detroit, Lansing and across the state.

The MSMS appeal for more physicians was presented at Grand Rapids November 14 to 100 physicians and community leaders from western Michigan by MSMS Secretary Kenneth H. Johnson, M.D.

Members of a special MSMS committee appointed to recommend courses of action for county medical societies to follow regarding health planning councils met recently with two invited guests. In photo at right, Mrs. Betty Tableman, executive director, Comprehensive State Health Planning Commission, visits informally with, left to right, MSMS Councilor Sidney Adler, M.D., Detroit; George T. Kelleher, M.D., Battle Creek; and MSMS Councilor John R. Pedden, M.D., Grand Rapids. In photo at left, Edwin S. Marsh, third from left, director, Health Planning Council of Michigan, talks during the dinner break with, left to right, MSMS Councilor A. C. Stander, M.D., Saginaw; MSMS Councilor Ralph R. Cooper, M.D., Detroit, and D. Bonta Hiscoe, M.D., Lansing. Otto K. Engelke, M.D., Ann Arbor, another member of the committee, was unable to attend.

Committee at Work to Develop Recommendations To County Societies re Planning Councils

At the September, 1968 meeting of The Council an ad hoc committee was authorized "To study recommended courses of action for component medical societies re health planning councils."

The special committee was a result of an action of the 1968 House of Delegates in adopting Resolution 3 "That the county societies be made cognizant of the role which can be played by them in taking leadership in the regional councils of the State Comprehensive Health Planning Commission."

Members at this first meeting received an in-depth review of the statutory requirements of this program from Mrs. Betty Tableman, Executive Director of the Comprehensive State Health Planning Commission. Mr. Edwin S. Marsh, Director of the Health Planning Council of Michigan, reviewed the voluntary role that can be made in comprehensive health planning, on a regional basis.

A report of the initial committee meeting will be received by The MSMS Council at its meeting December 18.

WSU Thyroid Program Lists Top Speaker

Sidney Ingbar, M.D., Boston, and Joseph Matovinovic, M.D., Ann Arbor, will be among the principal speakers at the Eighth Annual Wayne State University Thyroid Workshop, December 11. The program will be held at the Wayne County Medical Society auditorium.

Doctor Ingbar will discuss pharmacology of iodine and Doctor Matovinovic will trace the history of goiter.

Interested physicians may obtain copies of the complete workshop program from WSU medical school or Joel I. Hamburger, M.D., 20905 Greenfield, Southfield 48075.

SECOND MARGOLIS FILM OUT NOW ON SEX, TEENAGER

The premiere showing of "Sexuality and the Teenager," a new film produced by Doctor and Mrs. Frederick Margolis of Kalamazoo, was held recently at Western Michigan University.

Included in the program was a panel discussion featuring Tommy N. Evans, M.D., Chairman and Professor of the Department of Obstetrics and Gynecology, WSU; Stuart Finch, M.D., Professor of Psychiatry and Head of the Children's Psychiatric Hospital, U-M; Pauline Iyenaga, M.P.H., Family Life Education Consultant with the Bureau of Maternal and Child Health, MDPH; and Doctor Margolis.

This film is a sequel to the Doctor Margolis' popular film "Parent to Child About Sex."

MAP Invites MSMS Members Join Special AAP Tour to Spain

The Inauguratory Session of the American Association of the Professions will convene in Detroit on February 22, 1969, recess, and reconvene in Malaga, Spain, on February 23, 1969.

As the opening major event of its 10th Anniversary Year, MAP, in cooperation with seven other State Associations of the Professions, will formally launch the American Association of the Professions and concomitantly sponsor a trip to Spain.

This trip, in behalf of the originators of the national body, members of MAP and of its components — also includes the Michigan State Medical Society.

All members of MSMS are invited to make the trip and take their families with them, each at the attractive rate of $359. This includes eight days room and board at the Hotel Pepe, taxes and tips, the plane trip (DC-8-61F) to and from Spain, the meeting, reception and dinner which precedes enplaning. The flight from Spain will return March 2.

The AAP has been organized for several years but has never been structured and implemented, awaiting the development of several State Associations of the Professions — which has now been completed. The proposals up for adoption at the February 22 meeting will be those put forth at the preliminary national get-together at Harbor Springs in the summer of 1967.

MAP spokesmen point out that: "Hotel Don Pepe and Malaga are on the sunshine coast of Spain where, even during the coldest months, temperatures rarely dip below 60 degrees and more often than not, it is sunny and warm.

"By contrasting picturesque whitewashed villages, with some of the world's finest hotels, nightclubs and luxury apartments, this birthplace of Pablo Picasso harmonizes new resort living with ancient customs and traditions.

"On any winter's day, it is possible to ski on fresh snow in the Sierras during the morning, play a round of golf or a set of tennis by the sea, have a siesta on the beach in the afternoon, and pass an enjoyable evening in one of those typical Spanish bodegas.

"The non-athletes, who can forego lazying on the beach or swimming in the pools (the hotel has three of 'em) can take inexpensive side trips to Granada ($12), Tangier-North Africa ($35—by air), Gibraltar, etc."

MSMS members wanting more information may write or phone:

Michigan Association of the Professions
120 West Saginaw
East Lansing, Michigan 48823
Area Code 517 — 337-1725

WSU Symposium on Blood Jan. 17-18

Wayne State University's 17th Annual Symposium on Blood has been scheduled for January 17 and 18 at the McGregor Memorial Conference Center.

The theme will be "Disseminated Intravascular Coagulation." Sessions on the second day will be devoted to open topics in the area of hemostasis.

Committee members are Dr. Eberhard F. Mammen, Dr. Gordon F. Anderson, and Dr. Marion I. Barnhart, professor, all in the Department of Physiology and Pharmacology at WSU.

APPLICATION FORM — detach and mail to:

CRAVEN TOURS, INC.
202 M.A.C. Avenue
East Lansing, Michigan 48823
Tel: (517) 351-9210

Make checks payable to: Michigan Association of the Professions

PS/13

Name ________________________

Address ________________________
(street)

____
(city, state and zip code)

I/we wish to PLANE TO SPAIN with the American Association of the Professions and enclose a deposit in the amount of $100.00 per person (total deposit enclosed $________) I will be accompanied by: (give full names and relationship of all persons for whom deposit is enclosed)

____

I require a single room ☐ (Supplement $35.00)

I promise to pay the balance of $259.00 per person not later than January 21, 1969.
I have read and understand the terms and conditions of the trip, and agree to them.

Signed ____________________ Date __________

Doctor Loupee Dies; Served In Legislature

Sherman L. Loupee, M.D., 96 years old, who served in the State Legislature from 1939 to 1949 and who was selected by MSMS as "Physician-of-the-Year" in 1952, died October 31 in Dowagiac where he had practiced many years.

Doctor Loupee, who underwent surgery last year, was last honored by MSMS at its special Government Day during the MSMS Centennial observance in Detroit in 1965.

A former delegate for many years to both the state and national Republican conventions, Doctor Loupee had a long list of civic accomplishments. He was mayor of Dowagiac in the 1950's and for a time was a member of the Dowagiac Board of Education. He was long active in the Dowagiac Chamber of Commerce and Rotary Club.

Born September 4, 1872, he attended Eastern Michigan University and taught in the Dowagiac area before entering the old Illinois College of Physicians and Surgeons which later became a part of the University of Illinois Medical School. He was graduated in 1904 and began practice in Vandalia in 1904, moving to Dowagiac in 1919. While in Vandalia, he served as village president and school board president.

Several years ago, he was joined in practice by his son, George.

HARPER APPOINTS CHIEF OF STAFF

Sidney Miller, M.D., who has practiced 21 years in the Birmingham-Detroit area, has been appointed full-time chief of staff of Harper Hospital. He began duties December 1 at Harper, where he did his internship and residency.

Gerber Products Company has made an unrestricted teaching and research grant to the Department of Human Development, College of Human Medicine, Michigan State University. Left to right: Dr. R. A. Stewart, Director of Research at Gerber; William B. Weil, M.D., Chairman of the Department of Human Development.

Hunt to Lead Comprehensive Health Council

Six Michigan physicians are among the 32 citizens named by Governor Romney to serve as the Michigan Advisory Council on Comprehensive Health Planning.

Andrew Hunt, Jr., M.D., Dean of the MSU College of Human Medicine, has been named chairman of the Council.

Physicians named to the Council for one-year terms expiring Oct. 24, 1969, are: Vernon V. Bass, M.D., of Saginaw; James Hagans, M.D., of Kalamazoo; and Julian Priver, M.D., of Detroit.

Winston B. Prothro, M.D., of Grand Rapids, and Herbert A. Raskin, M.D., of Detroit, were named to two-year terms ending Oct. 24, 1970; and Myron E. Wegman, M.D., of Ann Arbor, will serve a three-year term expiring Oct. 24, 1971.

Keast Appeals For More Med School Faculty

Wayne State University's School of Medicine must continue to build its faculty if it is to double present student enrollment by the time new facilities are completed, President William R. Keast told the WSU Board of Governors recently. Mr. Keast emphasized that the need for doctors, nurses, hospital pharmacists and related medical technicians "was never greater."

He pointed out that the 1969-70 operating budget request of $49.26 million was needed if WSU was to carry out its educational responsibilities. The budget, approved by the board, represents an increase of $11.09 million over the current State of Michigan appropriation of $38.18 million. Student fees and other revenue total $15.13 million, bringing the total budget to $64.39 million for next fiscal year.

Mr. Keast said a major part of the budget increase represents funds which will permit Wayne State to fill its unique role in making a much needed impact upon urban problems facing Detroit and the nation.

Zoccolillo Heads Dow Life Sciences

Roger R. Zoccolillo was appointed assistant general manager of Dow Life Sciences, the Dow Chemical Company's worldwide pharmaceutical and human health business. In his new position, Mr. Zoccolillo will participate in the general management of the activities of Pitman-Moore Medical Company, Diagnostic Products, Bio-Science Laboratories, Lepetit S.p.A. and LIFE.

MATERNAL HEALTH DESK REFERENCE CARD NO. 1

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Spinal Anesthesia in Obstetrics

Safe dose of spinal anesthetic drugs used for the obstetrical patient at term in well established labor. (Primipara – 8 to 9 cm.
Multipara – 6 to 7 cm.)

For Vaginal delivery: (Saddle Block)
Procaine hydrochloride (Novocaine):
30 to 50 mg. with or without dextrose.
Tetracaine hydrochloride (Pontocaine):
2 to 5 mg. with 5% dextrose.
Dibucaine hydrochloride (Nupercaine):
2.5 to 3.75 mg. with 5% dextrose.

For Cesarean Section:
Tetracaine hydrochloride (Pontocaine):
5, 6, 7 or 8 mg. with dextrose.
Dibucaine hydrochloride (Nupercaine):
3.75 mg. to 5 mg. with 5% dextrose.
Procaine hydrochloride (Novocaine):
50 to 75 mg. with or without dextrose.

For safe management of spinal anesthesia in the Obstetrical patient:

1. Start intravenous fluids before giving spinal anesthesia with 18 or 19G needle, or 18G plastic cannula.
2. Take blood pressure, pulse, and respiration before giving spinal anesthesia.
3. Inject spinal anesthetic drug after a contraction – never during a contraction.
4. Keep patient's head elevated with pillow when patient is placed supine after giving spinal anesthesia.
5. Take blood pressure, pulse and respiration q 2 min. for first 10 min. after spinal anesthesia has been given, then q 5 min. for next 20 min.
6. Watch sensory anesthesia level for first 20 min. after giving spinal anesthesia.
7. Always have vasopressor drug (ephedrine, etc.) readily available to give intravenously, if necessary, during spinal anesthesia.
8. Always have a bag and mask, and oxygen available so that oxygen can be given by intermittent positive pressure if patient develops respiratory difficulty.
9. Always have the patient in the delivery room and keep patient in the delivery room when spinal anesthesia is given.
10. Always use careful aseptic technique in giving spinal anesthesia – be sure the drugs used have been autoclaved – (not cold sterilized).

NOTE: Use individual small ampules. **DO NOT** use stock bottle solutions.

11-1-68

MATERNAL HEALTH DESK REFERENCE CARD NO. 2

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Septic Abortion, With or Without Septic Shock: Diagnosis and Treatment

Cases of threatened or incomplete abortion, with or without associated septic shock, are a major problem in the current medical scene in Michigan. The history is usually one of cramps in the lower midline of the woman's abdomen, the passage of blood and clots, and tissue, in some cases from her vagina. She may have had feverishness and chills for the past 1 or 2 days. Some will admit to being 2 to 6 weeks overdue on the menses. All cases of septic abortion are best considered as being due to instrumentation of the uterus until demonstrated to be otherwise.

The findings on physical examination may be: temperature of from 96.8 to 105 F., subnormal levels indicating presence of severe infection and shock. Initial normal temperature does not preclude presence of a potentially severe and dangerous sepsis. Temperature, pulse and respiration rates should be recorded in all cases every 4 hours for the first few days so as not to fail to detect any initial wide swings, if and when they occur, these signal a dangerous degree of infection and must not be missed. Blood pressure may be normal or down to shock levels. Patient may not appear to be actually ill when first seen. Abdomen may evidence tenderness, rebound tenderness, even muscle rigidity. Uterus may be normal in size, or enlarged to size of 8 to 12 weeks of pregnancy, and may be intrinsically tender.

Sterile speculum examination may reveal bloody discharge from cervix canal; some clots and conceptual tissues may be present. Amount of discharge may vary from scant to profuse, may have foul odor. Cervix may be closed or open, firm or soft, normal in size or enlarged. There may be thickening, induration or tenderness of the bases of the broad ligaments. Tubes and ovaries may be normal and nontender, or enlarged, tender, prolapsed, and adherent to floor of lateral pelvic fornices.

Shock may be evidenced by blood pressures of 80/50, or lower, a pulse rate of 110, or higher, coolness and moisture of the extremities. **Shock may be due to blood** loss, **to sepsis, or to a combination of blood loss and sepsis.** Quickly determined white and red blood cell counts, and hemoglobin and hematocrit determinations, are of major aid in deciding the cause of shock. Shock most likely is **not** due to blood loss if patient's hemoglobin is 10 grams or higher, or hematocrit reading is 34 to 36 percent or higher. The venous pressure is the most reliable method of determining the need for intravenous fluids or blood transfusions. When shock thus is found not to be on basis of blood loss, it is most probably due to sepsis, in which event all major treatment efforts are best directed toward eradication of the infection. In such cases it is best not to give a blood transfusion, or more than a very slow drip maintenance volume of intravenous fluids, until such time as this can be accomplished without danger of overloading the cardiovascular system and possibly inducing decompensation. In cases of severe septic shock acidosis may be present, and blood pH determination should be made.

The following steps in treatment are given in time sequence of performance:

(1). Start 1,000 ml. bottle of 5 percent glucose in water intravenously; insert Foley catheter in bladder and connect for continuous drainage; start recordings on a fluid intake and output chart. At same time get blood samples for determination of potassium, sodium, chloride levels, the CO_2 percentage and pH values.

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(2). Perform at once sterile speculum vaginal examination, obtaining material for culture from high in cervical canal, or uterine cavity, and have it planted as soon as possible for culture and sensitivity testing (if these culture specimens dry out or otherwise die before they are properly planted the most important and crucial guide to the best means of saving the woman's life may be lost).

(3). Next, adequate amounts of penicillin and chloramphenicol are added to the bottle of 5 percent glucose. If the woman is very ill, 6 to 20 million units of aqueous penicillin and 2 to 3 grams of i.v. chloramphenicol should be added, and they can run in as a slow drip over a period of 12 to 24 hours, and longer as necessary; 1 to 2 grams of streptomycin may also be injected intramuscularly. If the woman is not so ill, smaller doses intramuscularly and orally can be given.

(4). Lost blood should be replaced when and as indicated by initial and repeated blood cell counts, hematocrit determinations and as indicated by the venous pressure. If patient's hemoglobin is less than 10 grams, or hematocrit is less than 30 to 34 percent, a blood transfusion should be given right away, if indicated by the venous pressure. Always listen at intervals for the development of basal rales posteriorly, and cut down on the rate of intravenous flow of the blood or glucose solution, or stop them entirely, as need be, in order to prevent cardiac decompensation and pulmonary oedema. If a woman is still in shock after her hemoglobin has been brought up to 10.5 to 11 grams, no more blood should be given for the time being; an intravenous drip containing an antihypotension agent can be run in as slow as 20 drops per minute using the glucose solution. This will permit additional time for combatting her infection. Monitoring with Central Venous Pressure is an excellent aid in managing blood volume and fluid replacement.

(5). General supportive care includes the maintenance of fluid and electrolyte balance, administration of nasal oxygen is indicated, the provision for necessary periods of sleep, and the giving of reassurance.

(6). Dilation and curettage should usually be done about 24 hours after commencement of antibiotic and general therapy, regardless of her febrile state, unless such procedure probably would prove fatal; it may be performed sooner than 24 hours if there is too much uterine bleeding. This is best done with ovum ring forceps under paracervical block using 1 percent xylocaine; demerol analgesia may also be indicated.

(7). If shock is not relieved by administration of blood and/or intravenous fluids, and antibiotic agents, metarminol bitartrate (Aramine) may have to be administered by slow intravenous drip, the drug being added to a bottle of 5 percent glucose. Such therapy must be closely watched by a physician, who will take and record the blood pressure every 30 minutes or so, and will discontinue administration of the drug as soon as the blood pressure rises to levels just above the shock state. If this drug is not sufficiently potent in its effect, levarterenal bitartrate (Levophed) may be administered instead. After the drug has been discontinued, the pressure may fall again, and it will have to be administered again, but this is much better than using it continually over too long a period.

(8). Corticosteriod therapy may be indicated in a few cases, and one of the available suitable products may be given intramuscularly or intravenously. The intravenous administration of 7½% sodium bicarbonate solution is indicated only if acidosis is present. It should be given not faster than 50 ccs in 20 minutes, and 50-100 ccs is usually an adequate dosage until a repeat blood pH determination can be made."

N.B. It is important to point out that the above therapy routine in general is also suitable in cases of regular puerperal sepsis. Also, if the infection is due to the gas bacillus, or to tetanus, then special therapy with antitoxin and antiserum is indicated; in fact some physicians give such injections in all cases of criminal abortion.

MATERNAL HEALTH DESK REFERENCE CARD NO. 3

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Use & Abuse of Oxytocics

Uterine rupture with resulting hemorrhagic shock (sometimes irreversible) and death of the mother as well as other unfavorable complications may result from injudicious use of oxytocics. The following Indications, Contraindications, and some possible dangers are presented as a guide to the use of this important group of drugs in obstetrics.

Some Indications for Oxytocics

1. INCOMPLETE ABORTION. To control uterine bleeding prior to surgical intervention or to complete the abortion without surgery.
2. SEPTIC OR MISSED ABORTION. To attempt emptying the uterus without surgical intervention.
3. HYDATIDIFORM MOLE. To stimulate the uterus to empty or during a molar abortion to hasten emptying or to control bleeding as with incomplete abortion.
4. ABRUPTIO PLACENTAE. After amniotomy if the cervix seems to promise early vaginal delivery.
5. POSTPARTUM UTERINE ATONY. Use oxytocics only after careful examination has ruled out retained placenta or laceration of the birth canal.
6. INDUCTION OF LABOR. For medical or obstetrical indications, such as:
   a. Diabetes mellitus
   b. Isoimmunization, Rh or other
   c. Dead fetus
   d. Toxemia – after the disease has been controlled for at least 12 to 24 hours
   e. Prolonged rupture of the bag of waters with the mother at or near term
   f. Suspected or proven amnionitis
7. UTERINE INERTIA IN UNOBSTRUCTED LABOR.
8. FOLLOWING DELIVERY BY CESAREAN SECTION.

Contraindications to Use of Oxytocics

The contraindications are as important as the indications, sometimes even more important. There is evidence that indicates measures other than oxytocics should be tried in the following conditions:

1. NORMALLY PROGRESSIVE LABOR. During the first or second stage.
2. PATIENTS WHO ARE POTENTIAL CANDIDATES FOR UTERINE RUPTURE
   a. Obstructed or possibly obstructed labor due to abnormalities of the bony pelvis or pelvic tumor,
   b. Malpresentations – abnormal vertex, transverse lie,
   c. Patients with previous cesarean section or myomectomy

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3. MULTIPARAE WITH FOUR OR MORE CHILDREN.
4. PATIENTS, 35 YEARS OF AGE OR OLDER.
5. PATIENTS WITH ALREADY OVERDISTENDED UTERUS. Such as
   a. Hydramnios
   b. Multiple pregnancy
   c. Fetus estimated to weigh over 9 pounds
6. PHYSICAL EXHAUSTION OF THE MOTHER.
7. PATIENT WITH UNENGAGED FETAL HEAD, ESPECIALLY IN PRIMIGRAVIDA.
8. WHERE WELFARE OF THE FETUS IS ALREADY IN DOUBT, indicated by
   a. Irregular heart rate,
   b. Heart rate persistently below 100 per minute, especially during a contraction
   c. Meconium-stained amniotic fluid in cephalic presentation

Administration of Oxytocics

In the use of oxytocics the following comments should be kept in mind.

EVERY PATIENT RECEIVING OXYTOCICS MUST HAVE SOMEONE, PREFERABLY A PHYSICIAN, OBSERVE THEM CLOSELY DURING THE FIRST 30 MINUTES LEST THE PATIENT HAVE A TETANIC CONTRACTION OF THE UTERUS OR DEVELOP A SEVERE HYPERTENSION.

1. PITOCIN Except after delivery of the placenta, intravenous infusion has replaced the intramuscular or subcutaneous administration of this drug.

   Five units (0.5 ml.) of the drug is placed in 500 ml. of 5% dextrose in water. The infusion is started at a rate of 8 to 12 drops per minute. Tetanic uterine contraction must be watched for and fetal heart tones checked frequently. If there is a tetanic uterine contraction or the fetal heart tones drop below 100 per minute, especially during a contraction, the infusion should be stopped immediately.

   During the first 30 minutes uterine contractions, fetal heart tones, blood pressure, and pulse are to be checked every 3 to 5 minutes. If significant abnormalities are found the infusion should be stopped and the situation carefully evaluated.

   After 45 to 60 minutes without any adverse effects the rate of flow may be increased up to 20 drops per minute if effective labor has not begun. Usually administration for 3 to 5 hours is sufficient for any one continued infusion.

2. SYNTOCIN This drug is given in the same dose, with the same technic, and with the same precautions as for Pitocin.

3. SPARTEINE SULPHATE (TOCASAMINE) The use of sparteine sulphate (Tocasamine) for the induction of labor or strengthening contractions cannot be recommended.

MATERNAL HEALTH DESK REFERENCE CARD NO. 4

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Suggested Standards of Prenatal Care

Good prenatal care significantly reduces maternal and perinatal mortality.

1. All pregnant women should have a complete history, and a general physical examination, including pelvic examination, with pelvic measurements and an evaluation of bony pelvic capacity, during the first trimester. Early examination is particularly important in high risk patients with major medical diseases and/or previous obstetrical complications.

2. Initial laboratory studies should include:
    a) Urinalysis; glucose, albumin, and microscopic examination of a clean midstream specimen (to rule out asymptomatic bacteriuria).
    b) Blood hemoglobin or hematocrit.
    c) Determination of Blood type, and the presence of the Rh factor, with Rh antibody titers in Rh negative women.
    d) A serological test for Syphilis.
    e) A smear for presence of Gonococcus, when indicated.
    f) A Papanicolaou smear from the cervix, where indicated by multiparity or age, or unless a smear has not been taken in over a year.
    g) Additional tests may be indicated, e.g., glucose tolerance test, kidney function tests, blood chemistry, etc.

3. The patient's current status as to Polio and Tetanus immunizations should be determined, and where deficient, they should be immunized for both, according to the individual judgement of the physician.

4. Early consultation may be warranted when the course of a medical illness may affect or be altered by the pregnancy. Pregnant patients with heart disease, Diabetes Mellitus, or other medical complications, require close observation and supervision during the entire pregnancy and puerperium.

5. Weight gain of not more than 15-20 pounds is advised in normal patients. Diet should consist of 1800-2000 cal. daily, with about 80 Gm. protein, 200 Gm. carbohydrate, and 90 Gm. of fat. Reduction to 14-1500 cal. daily may be advised for obesity. Daily sodium requirements may be limited to 1 Gm. or less in the presence of edema, hypertension, diabetes, multiple pregnancy, or a history of previous toxemia. Multiple vitamin and iron supplements may be indicated. (Because of possible teratogenic effects, especially during the first twelve weeks, drugs administered should be clearly indicated.)

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6. Prenatal examination should be made at least monthly during the first 6 months, every 2 weeks during the 7th & 8th months, and weekly thereafter. More frequent examinations may be indicated in special situations, such as threatened toxemia, Diabetes, heart disease, multiple pregnancy, etc.

   a) Unless urgent, diagnostic radiography should be deferred until after the pregnancy.
   b) Urinalysis for albumin and glucose should be performed at each office visit. Significant bacteriuria should be treated even if asymptomatic.
   c) Weight, blood pressure, fundal measurement, fetal position, fetal heart tones, presence of edema, presence of abnormal vaginal discharge, should be checked at each prenatal visit.

7. At 28 weeks gestation, repeat hemoglobin or hematocrit, breast examination, and the determination of Rh antibody titer in Rh negative women, should be done.

8. With a history of mid-trimester premature labor repeated speculum exam (as often as once weekly) may be indicated for the detection of the incompetent cervix.

9. Hospitalization for investigation, consultation, and treatment of all women with actual or suspected major complications of pregnancy should be considered particularly in the presence of increased blood pressure, persistent albuminuria, in a clean catch specimen, or both, since the prevention of pre-eclampsia is one of the chief goals of prenatal care.

Derived in part from Manual of Standards in Obstetric-Gynecologic Practice — The American College of Obstetricians and Gynecologists.

MATERNAL HEALTH DESK REFERENCE CARD NO. 5

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Immediate Post Partum Hemorrhage

There are very few more sudden, more abrupt, and more dangerous emergencies in all of medicine than an immediate post partum hemorrhage. The successful management of this catastrophe depends upon its anticipation, if possible, and upon prompt and almost automatic course of action when it occurs.

The three common causes are: uterine atony, retained placenta, or laceration of the birth canal.

PREVENTION There are certain conditions that are associated with an increased danger of post-partum hemorrhage.

1. Any condition that produces an over-distention of the uterus, such as multiple pregnancy, hydramnios, or an exceptionally large infant.
2. Any previous scarring of the uterus, such as a previous cesarean section, extensive myomectomy, or previous hysterotomy.
3. Inertia in the first stage of labor with poor uterine contractions.
4. Prolonged labor with maternal exhaustion.
5. Operative procedures, especially version and extraction.
6. Deep surgical anesthesia.
7. Any ante or intra partum bleeding, as from abruptio placenta, placenta previa, etc.

During their prenatal course, all patients should have their blood typed and an Rh factor determination performed. This information should be in the patient's chart on admission.

All birth rooms should be adequately equipped for prompt emergency care of the patient that is hemorrhaging. Adequate personnel should be available.

All patients admitted should have a hematocrit or hemoglobin determination.

Should any of the above predisposing conditions exist, certain preventative steps should be taken:

1. Blood should be made available.
2. When delivery becomes imminent, a 15 to 18 gauge needle or catheter should be placed in a vein, and kept open with 5 percent glucose and water. This latter precaution allows an oxytocic to be given intravenously after the birth of the infant or the placenta, it permits an infusion of an oxytocic in a dilution of 5 units in 500 cc glucose & water, it permits blood transfusion if this is necessary, and it permits withdrawal of blood for a clot observation test.

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DIAGNOSIS When a post-partum hemorrhage does occur, a definite and prompt routine of action is necessary.

1. The nursing attendant should as quickly as possible, give 5 units of oxytocic intravenously, as a single dose, draw blood sample for typing and cross-matching, start an infusion of 5 units of oxytocic in 500 cc of 5 percent glucose in water, and do a clot observation test when indicated. All this can be done with one needle insertion.
2. The physician should introduce one hand into the uterus, supporting that organ from the outside with the other hand. Any placental fragments should be searched for and removed. Systematic exploration for possible rupture follows, each lateral wall being palpated, next the fundus, then the anterior and posterior walls, with particular care in palpating the lower uterine segment. The cervix and vagina should be visualized. Adequate exposure is most important.
3. The attending physician should immediately request adequate help and consultation.

TREATMENT Uterine atony will usually respond to exploration and oxytocics (Pitocin, Syntocinon, & Ergot preparations), The infusion should be continued for several hours. An indwelling catheter is advisable to prevent overdistention of the bladder. Uterine packing or hysterectomy are seldom necessary.

Hemorrhage from retained placenta or fragments usually responds to the removal of the tissue.

Lacerations of the cervix and vagina should be detected and repaired promptly. Occasionally, a cervical laceration may be so extensive that hysterectomy is required. Rupture of the uterus demands exploration abdominally, and frequently hysterectomy. Rarely, the rupture can be repaired and the uterus spared.

Blood loss should be promptly replaced. When blood is not yet available, plasma expanders should be administered to maintain blood pressure.

Less frequent causes of immediate post-partum hemorrhage may be encountered. Hypofibrinoginemia (abruptio placenta, dead fetus syndrome, amniotic fluid embolus), other bleeding diatheses, and coagulation defects, placenta accreta, inversion of the uterus: all should be considered, and appropriate therapy instituted.

Prompt recognition, prompt management, and judicious blood replacement constitute the key to success in the management of immediate post-partum hemorrhage.

MATERNAL HEALTH DESK REFERENCE CARD NO. 6

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Premature Separation Of The Normally Implanted Placenta

This complication of pregnancy is an important contributor to maternal mortalities in the State of Michigan, but is even more of a contributor to peri-natal mortalities. In its severe form, still-birth often accompanies "Abruptio Placenta."

Abruptio Placenta must always be considered in the differential diagnosis of 3rd trimester bleeding, before or during labor. It is commonly associated with toxemia of pregnancy, pre-existing hypertension, with or without super-imposed toxemia, increasing maternal age, multiparity, uterine fibroids, renal disease, usually chronic glomerular nephritis, and hydramnios with sudden decompensation from rupture of the membranes. It may also occur independent of these conditions.

PATHOLOGY

Maternal blood loss from the separated portion of the placenta, produces the clinical picture and possibly afibrinogenemia. The bleeding may be vaginal or hidden (often with more severe symptoms). As the separation increases, the uterus reacts with contractions which may range from productive, rhythmical contractions to board-like tetany. Pain, a prominent feature, is produced by stretching of the uterus by the retroplacental bleeding (concealed bleeding). Often the pain is localized by the patient to one area of the uterus.

CLINICAL PICTURE

The severity of symptoms and findings, vaginal or concealed, resulting pain, consistency and tenderness of the uterus, degree of maternal shock and condition of the infant, are determined by the degree of placental separation.

As the clinical picture worsens, the blood ceases to clot due to the reduction of circulating maternal fibrinogen. Fetal embarrassment, fetal jeopardy, and fetal death, occur in succession as the condition worsens.

MANAGEMENT

If the diagnosis is established or suspected, management should proceed as follows:

(1). Appraise the patient: a. as to the severity of the disease, b. and the state of blood coagulability, c. estimate the probable length of labor, all things considered.

(2). Draw sufficient blood from the mother for typing and cross-matching, and for a clot observation test, as a simple method of determining blood coagulability. (5cc of blood in a clean tube should form a firm clot in 5-10 min.) A circulating fibrinogen level should be determined at this time, and followed at hourly intervals. (Normal — 150 mg% or more.)

(3). Start an infusion of 5 percent glucose in water, thru a large needle (No. 17 or 18).

(4). Call a consultant.

(5). Perform a vaginal examination with a double set-up:

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  a. To determine the degree of effacement and dilatation of the cervix.
  b. To rupture the membranes. This should always be done, once the diagnosis is established, no matter what type of delivery may follow.

(6). Give whole blood transfusions (fresh blood if available) as indicated by blood loss and degree of shock. Blood over 24 hours old is poor in fibrinogen. Blood loss is often under-estimated.

(7). Give human fibrinogen if hypofibrinogenemia exists, when there is failure to respond to fresh blood infusion.

(8). Delivery is the immediate goal for abruptio placenta and its complications, and should be effected by whatever route seems safest for mother and infant.
  a. VAGINALLY, if the cervix is "ripe," if the severity of abruption and hence the amount of shock and evident bleeding is not too severe, and if delivery can be expected in a very short time (consistent with maximum safety of mother and infant).
  b. BY CESAREAN SECTION, if the cervix is not "ripe," with expectation of a labor longer than 4-6 hours, if the hypofibrinogenemia is corrected or quickly correctable, in severe abruption, or if delay for vaginal delivery would jeopardize the life of mother and infant.

An excellent summary on Abruptio Placenta has been written by C. Paul Hodgkinson, MD, and John Neufeld, MD, appearing in Clinical Obstetrics & Gynecology, September, 1960, published by Paul B. Hoeber, Inc., Medical Division of Harper & Brothers.

"Because of the seriousness, as well as the risk of post-transfusion hepatitis, blood, plasma, or dried fibrinogen infusions should be rigorously restricted to those recipients with clear cut indications for its use" — communication from H. D. Anderson, Ph.D., Biological Products Section, Michigan Department of Health.

MATERNAL HEALTH DESK REFERENCE CARD NO. 7

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Toxemia Of Pregnancy-Pre-Eclampsia-Eclampsia

Toxemia of pregnancy is characterized by edema, hypertension, and proteinuria, first appearing during the second half of pregnancy, except with hydatidiform mole. It continues to be an important cause of maternal and infant mortality, but its progression can be prevented by early recognition and proper treatment.

ETIOLOGY

Not clearly established. Occurs more often in young primagravadas than in older multiparas. Mothers with diabetes, multiple pregnancy, hypertensive vascular disease, pyelonephritis, glomerulonephritis, and hydatidiform mole, are particularly susceptible.

PATHOPHYSIOLOGY

The toxemic process occurs in two phases (not clearly demarcated): sodium retention phase, and sodium retention plus vasoconstriction. Edema is based on sodium retention. The generalized vasoconstrictive phase causes hypertension, reduced renal blood flow, (decreased urinary output), and characteristic retinal changes (retinal sheen and decrease in caliber of retinal arteries). Cerebral ischemia is the cause of coma and convulsions.

DIFFERENTIAL DIAGNOSIS

Toxemia must be differentiated from hypertensive vascular disease, HVD plus toxemia, pyelonephritis, and glomerulonephritis. Retinal changes and complete urinalysis of a clean voided mid-stream specimen, aid in differentiating. Culture and colony count help to diagnose pyelonephritis. RBCs and casts in urine point toward glomerulonephritis. Toxemia produces albuminuria, but no WBCs or RBCs are found in urine, in early stages.

CLINICAL COURSE

First evidence of abnormality: weight gain exceeding one pound per week followed by edema, then proteinuria. Rise of 20-30 mm of Hg above base-line BP is suggestive. All signs are exaggerated as condition worsens.

CHARACTERISTIC SYMPTOMS

No symptoms of early pre-eclampsia, only physical findings of excessive weight-gain, edema, and blood pressure rise. Headache, blurred vision (edema of retina), scotomata, occur as late symptoms. Epigastric pain and vomiting indicate impending eclampsia.

PREVENTION

Best preventative is observation and early recognition, i.e., good prenatal care. Low sodium diet, restriction of activity (phenobarbital, ½ gr. qid, decrease in physical and emotional stress), careful, frequent observation, plus thiazide diuresis (if indicated) may prevent progression to generalized vasoconstriction and true toxemia.

TREATMENT

Principles

Recognize developing pre-eclampsia, apply available measures, and if no response, deliver.

Office Treatment

1. Restrict activity (as above under prevention).
2. With excessive weight-gain, prescribe thiazide diuretic (hydrochlorothiazide) 25-50 mg. daily; (chlorthalidone) 50 mgs daily to prevent progression.
3. Re-examine every 3-5 days.
4. If poor response, limit sodium intake to 2-4 Grams daily. With weight loss stable or dropping BP, and negative urine, re-examine every 3-5 days. Diuretic and anti-hypertensive effect of thiazides, may be potentiated by Acetazolamide, 250 mg. bid, every 3-5 days.
5. If patient fails to respond, with further weight gain, and has increasing edema and BP, proteinuria, or toxic symptoms, admit to hospital. DO NOT ATTEMPT IMMEDIATE DELIVERY. Stabilize the patient's condition before attempting delivery if this is possible.

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Hospital Treatment

1. Call consultant obstetrician.
2. Weigh patient daily and record.
3. Record intake and output.
4. Take and record BP at least four times daily.
5. Determine daily quantitative 24 hour albumin.
6. Check hematocrit and type and cross-match for available blood.
7. Check serum uric acid. (Thiazides may cause rise.)
8. Order low sodium diet (1.5 to 2.0 Grams).
9. Re-check hematocrit and uric acid every 3 days.
10. Continue diuretic therapy, if indicated. Successful therapy is suggested by: 1. weight loss, 2. stabilization or fall in BP, 3. reduced proteinuria, 4. stable hematocrit, 5. normal uric acid.

Patient should remain in hospital until cervix is ripe for induction, and should then be induced. Occasionally, if true recovery, may be sent home if under 32 weeks gestation. Persistent albuminuria is indication for induction. If sent home, should be followed closely by obstetrician, and examined once or twice weekly.

Patients who have had eclampsia, must **NOT** be sent home until delivery is accomplished and adequate post-partum recovery is accomplished.

Failure of therapy is indicated by reversal of above findings (Paragraph 4 under office treatment), indicating progression to generalized vasoconstriction.

Treatment of Severe or Fulminating Toxemia

A variety of anti-hypertensive agents, alone or in combination, may be used, patient being monitored constantly.

Anti-hypertensive Agents

1. Reserpine, 2.5 mg. IM, every 12 hours, attempting to control vasoconstriction.
2. Hydralazine (Apresoline), 20-30 mg. IM or IV, slowly.
3. Veratum, 2.5 mg. IM, when diastolic pressure arises above 90 mm. Hg. as indicated.
4. Various combinations or other anti-hypertensives are available and useful. McCall's solution (Unitensen, 30 mg. and Apresoline, 20 mg. in 1000 cc of glucose in water) may be given as slow IV drip, provided physician personally remains at bedside during administration.

Other Measures

Many authorities advise administration of magnesium sulfate in eclampsia according to the following schedule.

a) 4 grams in 20% solution — IV — at the rate of one gram per minute, then 10 grams in 50% solution IM (3″ needle No. 20).
b) If convulsions continue repeat 4 grams in 20% solution IV.
c) 5 grams in 50% solution IM q 4 hours until delivery and for 24 hours after.

CAUTION: a) Patellar reflex must be present
b) Urinary output greater than 100 cc every 4 hours.
c) Normal respiration must be present.

If convulsions occur, pentobarbital sodium, slowly IV, will usually control them.

When severe pre-eclampsia or eclampsia is stabilized, usually accomplished in 12-48 hours, DELIVER THE PATIENT. Medical induction with oxytocic drip often succeeds even with unfavorable cervix. If not in active labor in 8-12 hours, deliver by Cesarean Section.

Abruptio Placenta may accompany toxemia (See Desk Reference Card No. 6).

POST-DELIVERY CARE

Continue pre-delivery care until:

1. BP is stabilized, 2. Urinary output is adequate, 3. Symptoms are relieved.

Essential Hypertension

Women with essential hypertension are prone to develop acute toxemia with similar signs, but more fulminating course. Treatment is similar to Pre-eclampsia.

Abruptio Placenta can usually be prevented by early delivery if acute toxemia develops.

MATERNAL HEALTH DESK REFERENCE CARD NO. 8

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)
(The material below is derived from Technical Bulletin No. 5, March, 1965, edited by the American College of Obstetricians and Gynecologists)

Infant Resuscitation

All obstetricians, anesthetists, house officers, and nurses assigned to the delivery room should receive detailed instructions and supervised training in the resuscitation of newborn infants.

Responsibility for the organization, implementation, and supervision of such training should be clearly established in all hospitals caring for maternity patients. Often this is shared by the Chief of Obstetrics and Gynecology with the Chief of Anesthesiology. Resuscitation of the newborn in the delivery room is the responsibility of the attending obstetrician. Situations in which resuscitation is required often occur unheralded. The most experienced person present in the delivery room should be delegated by the obstetrician to assist in the establishment of respirations. He should not delay calling those skilled and experienced in administering positive pressure oxygen and in intubating the larynx to assist him or to assume the responsibility for resuscitation when these methods might appear needed.

The fundamentals of establishing respirations and of active resuscitation of depressed infants are outlined in this section.

Fundamental Principles

1. The normal newborn baby usually breathes within a few seconds after delivery. Most will establish respiration within one minute and need little or no assistance. Some, however, may require active resuscitation.

2. Amniotic fluid will flow from the mouth and nose by gravity. Thick fluid or mucous requires direct pharyngeal aspiration.

3. Prolonged pharyngeal stimulation (as with a catheter) may inhibit respiratory efforts and decrease the heart rate.

4. The basic principle in establishing respirations for the normal and for the sick infant is to provide an open air-passage as quickly and reliably as possible after birth.

5. The alert infant usually can open his own air-passage and keep it open. Depressed and comatose infants do not have the muscle tone and strength to open their air-passage against the force of gravity and surface tension. The simple maneuver of moving the tongue from the posterior pharyngeal wall either directly or by lifting the jaw forward will provide an open airway in most cases.

6. The physiological condition of the newborn infant should be assessed within one minute after birth. Several types of observation may help make this evaluation:
    a. General Condition. The newborn may be assessed as alert, depressed or comatose (the limp, "rag doll").
    b. Heart Rate. If the heart rate is below 100, hypoxia probably is present. The heart in the comatose infant cannot be heard at rates much below 40 per minute, but umbilical pulsation may be visible. The amplitude of umbilical pulsation often is a good indication of circulatory status in the newborn.
    c. Apgar Score. The newborn is rated 0, 1, or 2, in each of five categories: (1) heart rate, (2) rhythmic respirations, (3) muscle tone, (4) reflex irritability, and (5) color. A score may range from 0 to 10; a baby with a score of 10 is a near-perfect baby, physiologically. (Apgar ratings should be determined at one and five minutes.)

Management of the Newborn

1. GENERAL
    a. KEEP THE HEAD AND FACE OF THE INFANT DOWN AND THE MOUTH OPEN AT ALL TIMES DURING AND IMMEDIATELY AFTER DELIVERY.
    b. During or immediately after birth gently aspirate the nasopharynx or oropharynx once or twice with a soft rubber bulb syringe or a suction catheter.
    c. After the cord is clamped, the infant should be placed on the receiving table where further care may be given. The infant should be evaluated at this time and the decision made as to necessary resuscitative steps. If possible, this should be done within one minute of birth.
    d. Procedures such as care of the eyes, complete physical examination, et cetera, should not be done until spontaneous respirations are well established.
    e. It is important that the infant be observed carefully during the first ten minutes of life to insure that adequate respiration continues.
    f. The infant should be wrapped to maintain normal body temperature.
2. THE ALERT INFANT, APGAR SCORE 8-10, HEART RATE OVER 100.
    No additional treatment other than continued observation is necessary.

3. THE DEPRESSED INFANT, APGAR SCORE 5-7, HEART RATE BELOW 100.
   a. Place a two-inch thickness of rolled towel under the shoulders if the infant is in the supine position, or a one-inch thickness in the axilla if the semi-lateral position is chosen. Be certain that the head is hyperextended and that the tongue is pulled forward.
   b. Stimulate the baby by flicking and stinging the toes, feet, or buttocks, and by blowing cold oxygen over the face. Too vigorous and too painful stimuli may, however, add to the depression.
   c. Occasionally additional pharyngeal fluid may accumulate. This should be aspirated gently, but not continuously, until the infant shows active swallowing.

4. THE COMATOSE INFANT, APGAR SCORE 0-4, HEART RATE BELOW 100.
   a. The apneic or comatose baby needs prompt attention by trained personnel.
   b. This baby should be placed immediately on the receiving table, the head hyperextended, the airway cleared, and the pharynx carefully suctioned.
   c. Mild painful stimuli occasionally may serve to rouse the sleepy infant to respiratory effort.
   d. If apnea and depression persists for more than one minute, artificial ventilation should be instituted with mouth-to-mouth breathing, intermittent positive pressure oxygen with the bag and mask unit, or a positive pressure resuscitator. These should be accomplished by an operator familiar and skilled in the use of the apparatus and in maintaining a patent upper air-passage.
   e. Pressure between 15-20 cm. H_2O usually are safe for repeated inflations. Initial inflation, however, may require 25-35 cm. H_20, and, occasionally, 35-50 cm. H_2O. Several types of apparatus are available which deliver safe pressures, but at the present time no mechanical device for delivering oxygen under pressure is sufficiently flexible to meet all situations. The use of alternating positive and negative pressures is of no proven value and may do harm.
   f. If the thorax does not expand with intermittent positive pressure oxygen, laryngospasm and/or obstruction from the tongue may be present. Correct the latter with pressure at the angles of the mandible or with proper placement of an oropharyngeal airway. Laryngospasm can be treated by forceful prognathous and positive pressure oxygen or tracheal intubation.
   g. Intubation of the larynx should be done by those skilled in this technique. It is indicated in the following conditions:
      (1) If the improvement in the normal depressed infant has not been obtained after pharyngeal and laryngeal toilet and intermittent positive pressure oxygen.
      (2) For the obviously limp, "rag doll" baby regardless of heart rate and despite occasional gasps.
      (3) For any episode of cardiac arrest in the infant, including stillborn infants delivered for fetal distress.
      (4) For tracheal aspiration of infants born in thick meconium or infected amniotic fluid.
   h. Intubation of the larynx should be done under direct vision using a proper infant laryngoscope.
      (1) After inserting a snug-fitting endotracheal tube, foreign particulate matter (vernix, blood) should be aspirated once through the tube before blowing gas into the lungs.
      (2) Intermittent positive pressure oxygen should be given by mouth-to-tube, bag and mask, or mechanical resuscitator. High pressure may be necessary initially to inflate the non-aerated lung. Subsequent inflations are administered at lower pressures.
      (3) The pharynx should be cleaned of fluid before removing the endotracheal tube because gastric content may accumulate in the pharynx subsequent to ventilation of the lungs.
   i. External cardiac massage is indicated if 30 seconds of lung ventilation do not produce signs of improving circulation. This is done by compressing the heart between the sternum and the vertebral column.
   j. Intracardiac adrenalin is indicated at one minute if ventilation of the lung and external cardiac massage do not show signs of improving circulation. 2.0 cc. of a 1:10,000 solution of adrenalin in saline are introduced through a 1½" needle 2 cm. from the midline in the fourth intercostal space.
   k. Respiratory stimulants are of no value (Metrazol, Alpha-lobeline, Coramine, et cetera). (Nalline hydrochloride may be of value in the prevention of narcotic apnea in over-dosage of the mother).

5. ADDITIONAL MEASURES.
   a. Record the infant's condition at birth and the Apgar Score at one minute. Also record the time of sustained respirations. In addition, record all resuscitative efforts on the Newborn Physical Examination sheet.
   b. Every infant should receive a careful physical examination in the delivery room to discover congenital malformations. If dyspnea, cyanosis, stertor, or excess pharyngeal secretions persist, diagnostic studies to rule out pneumothorax, tracheo-esophageal fistula, diaphragmatic hernia, and hypoplasia of the lung should be made before transfer to the observation nursery. A 10 Fr. suction catheter should be passed into the pharynx to rule out choanal atresia. Passage of a catheter into the stomach will help diagnose a tracheo-esophageal anomaly.
   c. Antibiotic administration should be carefully considered after extensive resuscitative measures.
   d. Transfusion is indicated when the baby shows extreme pallor and shock secondary to fetal blood loss. It should be seriously considered if one infant of a multiple pregnancy is alert and the other shows depression and pallor.
   e. CO_2 levels should be determined as quickly as possible.

6. INDICATIONS FOR EXTENDED SPECIAL ATTENTION.
   a. Resuscitated infant — initial Apgar Score of 4 or less, comatose at birth.
   b. Premature infants.
   c. Infants delivered by cesarean section.
   d. Infants with congenital malformations.
   e. Infants of diabetic mothers.
   f. Respiratory distress syndrome.
   g. Iso-immunization.
   h. Maternal drug addiction.

MATERNAL HEALTH DESK REFERENCE CARD NO. 9

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

The Management of the RH- Sensitized Patient

1. An Rh determination and an antibody screen for atypical antibodies should be done on all maternity patients at the time of the initial visit to the physician or clinic. If the antibody screen is positive, the antibody should be identified and titered. If the screen test is negative, the screen test should be repeated at 26-28 weeks.

2. If the patient has antibodies in the Rh system, amniocentesis should be performed at 28-29 weeks and repeated at intervals, according to the results. If there is a history of previous still-births or fetal hydrops, it should be done earlier (24 weeks).

TECHNIQUE OF AMNIOCENTESIS

1. The amniocentesis should be performed one inch below and one inch lateral to the umbilicus, on the side of the fetal small parts, or in any area where fetal small parts are palpable. (It may be necessary to obtain a single anterior-posterior film of the abdomen to be sure.) Be sure the patient's bladder is empty.

2. The abdomen should be prepared with the same careful technique used for abdominal surgery.

3. The site chosen and the underlying tissues should be anesthetized with a local anesthetic agent such as 1 percent Xylocaine.

4. While holding the fetal head with one hand, a 5 inch, 18 gauge spinal needle with stylet should be introduced into the amniotic cavity. Release the needle so that if it contacts the fetus the point will move freely.

5. Remove the stylet and withdraw 10 cc. of amniotic fluid into a sterile syringe. Replace the stylet and withdraw the needle.

6. It is important to put the fluid immediately into a sterile opaque container to *prevent exposure to light.*

7. As soon as possible after the amniocentesis, centrifuge the fluid for 15 minutes (a standard centrifuge is satisfactory) and remove and save the supernatant. This will remove any blood or vernix which might interfere with the examination.

8. The fluid may be preserved for several weeks, refrigerated in a sterile container, without loss of critical absorption peaks if it is not exposed to light.

9. If fluid is not obtained on the first attempt, choose another area and repeat the procedure. If blood is obtained, a sample should be sent for blood type and Rh determination, and a second tap should be attempted. Blood obtained will usually be maternal blood. If it should be fetal, Coombs and hemoglobin determinations will give much information about the condition of the infant.

POSSIBLE DANGERS

1. Increased sensitization of the mother. This is theoretically possible but seems to be a very infrequent incident.

2. Injury to the placenta. This too has been reported but infrequently.

3. Injury to the baby. Because of this possibility, it has been suggested that the fetal position be determined accurately and the needle be pointed away from the fetal head.

4. Amnionitis. Sterile technique is most essential.

EXAMINATION OF THE FLUID

The fluid is examined in a spectrophotometer. The absorption curve consists of the optical density plotted against the wave length of the light passing through the fluid at various wave lengths between 350 and 650 millimicrons. This is plotted on a logarithmic scale. The difference of the optical density at 450 mu between the speci-

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men and the normal is determined. This difference is the figure reported by the laboratory. It is then plotted on the accompanying chart.

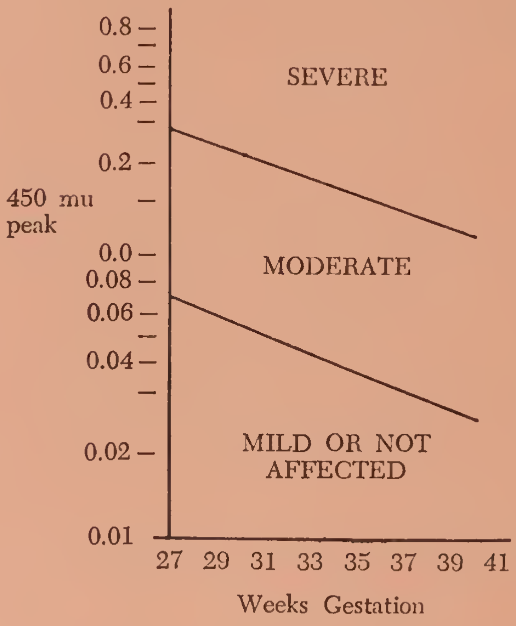
The attending obstetrician who is not well versed in these procedures should seek consultation at an early stage of pregnancy.

INTERPRETATION OF THE RESULTS

1. If the figure reported is low and remains low at the time of the second amniocentesis, the infant will be Rh negative, or Rh positive but mildly affected by the disease. Spontaneous labor may be allowed to ensue. This does not mean that the infant may not require exchange transfusion. It does mean that the baby will be born with an adequate hemoglobin and in good condition for the exchange transfusion.

2. If the figure reported is in the mid range, the infant will probably require exchange transfusion and should be delivered prior to term. The higher a reading in the middle zone, the more urgent is the indication for early delivery. Babies with repeated upper zone readings should be delivered as soon as they are mature (usually 36 weeks).

3. If the figure reported is high (in the severe range), there is no question that the infant is severely affected by the disease. An intra-uterine transfusion should be considered unless the infant is mature enough to be delivered. This is especially important if this mother has lost previous infants from erythroblastosis.



TIMING OF AMNIOCENTESIS

1. Initial fluid taken at 28 weeks.
2. Low and low middle zone reading: Repeat in two weeks.
3. High zone readings: Repeat in one week. If less than 36 weeks, transfuse. If 36 plus weeks, deliver. At 26-28 weeks, repeat tap weekly.
4. Middle zone readings: Repeat taps at 10 day intervals.

PROGNOSTICATING FROM SERIAL READINGS

1. Falling values indicate less severe disease, eg 1. upper middle zone, 2. lower middle zone — the infant may be only moderately affected — some have even been Rh negative.

2. Rising readings indicate a worsening condition. A rise into the high zone is very serious. Intra-uterine transfusion or immediate delivery are usually indicated, depending on fetal maturity.

In communities where laboratory facilities are inadequate for testing the supernatant amniotic fluid, specimens may be mailed to either of the addresses listed below:

1. c/o J. Robert Willson, M.D.
   Professor & Chairman, Dept. of Obs & Gyn, Women's Hosp.,
   U. of Mich. Medical Center
   Ann Arbor, Mich. 48104
2. T. N. Evans, M.D.
   Professor & Chairman, Dept. of Obs & Gyn, Wayne State University of Medicine
   1400 Chrysler Expressway, Detroit, Mich. 48207

Complete identification of the specimen and a short history would be of value, and either of the above will offer consultation in management.

MATERNAL HEALTH DESK REFERENCE CARD NO. 10

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Ectopic Pregnancy

Since the great majority of pregnancies occurring outside the uterine cavity will be found in the tube, this discussion will be focused upon the diagnosis and treatment of tubal pregnancy. Being constantly alert to the possibility of a tubal pregnancy in any woman in the reproductive age is imperative if it is to be diagnosed and treated before serious complications develop.

SYMPTOMS AND DIAGNOSIS

Postponed, protracted, or any abnormality of menstruation would be suggestive of extra-uterine pregnancy. When accompanied by pain, often vaginal bleeding, low-grade fever, leukocytosis, and/or a mass to one side of the uterus, ectopic pregnancy must be the major working diagnosis until proper evidence can exclude it.

Symptoms vary with the stage of the disease when the patient is seen — before, during or after rupture.

Before rupture the pain is vague. Perhaps it may be felt as discomfort, indefinite distress, soreness, or very mild cramps. There is no fever or leukocytosis because there is little peritoneal irritation from blood in the abdomen. Often the mass is too small to be palpated on bimanual examination.

During rupture a positive diagnosis is more easily made. The pain is more severe, located on one side of the lower abdomen, with frequent referred shoulder pain. Exacerbation of pain followed by complete relief is particularly significant. The cervix is exceedingly sensitive to movement. Vaginal bleeding may be intermittent or constant, but seldom is it profuse. Fever and leukocytosis may be present because there is bleeding into the peritoneal cavity. A tense, pulsating, exquisitely tender mass now is usually felt with ease.

After rupture, the diagnosis is usually easy because of the history of agonizing, one-sided pain, signs of massive internal hemorrhage, followed by nausea, vomiting, fainting, shock and collapse. The pulse is rapid and feeble, and the skin is cold and pallid. In addition there is shallow breathing, air hunger, restlessness, and extreme anxiety.

On the affected side, the abdominal wall is tender and rigid, and a soft doughy mass may be present. At times it may extend over the entire abdomen.

In addition to the above symptoms and findings, there often is a significant past history of infertility, "one child sterility," or a previous ectopic pregnancy.

PROCEDURES USED IN ESTABLISHING A DIAGNOSIS

1) Pregnancy tests, if positive, will demonstrate the presence of living chorionic tissue. If negative, the test is valueless.

2) Pelvic examination, usually without anesthesia, is essential.

3) Culdocentesis can be an important aid, and is indicated in any suspected case. With the patient in the lithotomy position, the posterior lip of the cervix is pulled an-

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teriorly with a tenaculum and the vaginal wall is punctured approximately ¾″ posterior to the cervix, using a long No. 16 or 17 needle, which has been slightly blunted, and a 10 c.c. Luer-lok syringe. If free, blood-stained watery fluid is obtained, the diagnosis of intra-abdominal bleeding is indicated, and if the fluid removed does not clot, it is established.

4) Dilatation and Curettage may be helpful when reports can be obtained promptly. The presence of chorionic villi is proof of intra-uterine pregnancy, but the finding of decidua without villi is suggestive of tubal pregnancy. (Decidua may be found post-abortion.)

5) Posterior colpotomy and culdoscopy may be helpful for those trained in these techniques, but it is recommended that proper exploration of the pelvis and salpingectomy is always accomplished more definitively and safely through a lower abdominal incision.

DIFFERENTIAL DIAGNOSIS

This is concerned chiefly with the differentiation from abortion, salpingitis, appendicitis, and pelvic tumor.

In abortion the bleeding is usually more profuse, the pain intermittent as uterine cramps. Villi and fetal parts may be seen in the expelled material.

In salpingitis there may be known gonorrhea, positive smears, purulent discharge, gradual onset, no enlargement or softening of the uterus, and a less circumscribed (usually bilateral) mass.

In appendicitis there are no menstrual abnormalities, no evidence of pregnancy, and usually no mass.

Ovarian cysts are usually much larger than a pregnant tube, pain is uncommon, menses have usually been normal, and the uterus feels non-pregnant.

Mittelschmerz occurs at mid-cycle.

MANAGEMENT

It is best to remove the offending ectopic gestation as soon as possible after the diagnosis has been established. Prompt operation before or during rupture will avoid the frank bursting of the tube with its tragic consequences.

In acute tubal rupture, blood should be drawn for CBC, Rh testing, typing and cross-matching, and IV fluids started with a large gauge needle or catheter. A second intravenous route should be established. An operating room should be ready and operation begun at once. Blood should be transfused as soon as available. Those who await recovery from shock lose precious time and more precious blood.

Rapid entry into the peritoneal cavity is essential. Palpation should promptly reveal the side involved, and clamping and ligation will control bleeding, often with dramatic improvement in blood pressure and general condition of the patient. Peritonealization should be attempted, if feasible. In massive hemoperitoneum, sacrifice of the ovary may be unavoidable. In cases diagnosed before rupture, preservation of the tube may be possible.

The operation should be quickly done and no other elective operation should be considered. When the bleeding is stopped, do no more — “get in and get out.”

Removal of clotted and unclotted blood found in the peritoneal cavity may be helpful in prevention of peritoneal irritation, infection, and formation of adhesions, with subsequent damage to the remaining tube.

MATERNAL HEALTH DESK REFERENCE CARD NO. 11

(Sponsored and Prepared by the Committee on Maternal Health, Michigan State Medical Society)

Diabetes and Pregnancy

1. Pregnancy is accompanied by diabetes in 2 per cent of cases. Pregnancy aggravates the diabetic state and diabetes in turn seriously affects the outcome of pregnancy. Maternal mortality is not increased despite the fact of increased maternal morbidity. There is a considerable perinatal mortality – the classic accident being fetal death in utero.
2. **DETECTION:** is most important. A urine analysis should be performed at each prenatal visit. Glycosuria must always be investigated. Attention is directed in addition to those women who have any of the following: a family history of diabetes, history of a birth of an infant weighing 9 lbs. or more, unexplained stillbirth, anomalies, unexplained by diagnosis, obesity or suggestive vascular lesions. Minimal investigation would involve securing a fasting and 2-hour postprandial blood sugar level. Levels above 110 and 130 (true glucose) suggest diabetes, and above 130 and 150 are diagnostic of overt diabetes.

   In the absence of frank diabetes a 3-hour glucose tolerance test should be done after the administration of 100 grams of glucose orally. Normal result – fasting 90, 1 hour 165, 2 hours 145, 3 hours 125 (mgm% true glucose). If two or more of these levels are exceeded but the fasting level remains less than 110 mgm%, the patient must be regarded as having chemical diabetes.

   For a valid result the patient must have had normal dietary intake for 3 days prior to the test and must have retained the glucose load.

   It may be necessary to recheck a questionable result in the succeeding trimester. After delivery gestational diabetes clears very rapidly so that a positive glucose tolerance test may not be obtained in the puerperium.

   Renal glycosuria occurs frequently during pregnancy, presumably due to a marked increase in the volume of glomerular filtrate.
3. **CLASSIFICATION:** (Priscilla White)
   - A. Chemical diabetes (abnormal response to glucose tolerance test).
   - B. Diabetes with onset after the age of 20 years and less than 10 years in duration.
   - C. Diabetes with onset between the ages of 10 and 19 years or of from 10-20 years duration.
   - D. Diabetes with onset prior to 10 years of age or of more than 20 years duration or having demonstrable retinal or leg vessel changes.
   - E. Diabetes with roentgen signs of pelvic vascular disease.
   - F. Diabetes with nephropathy.
   - G. Diabetes with multiple obstetric failures.
4. **EFFECT OF PREGNANCY ON DIABETES:**

   Pregnancy makes increasing demands on maternal insulin reserve and is thus diabetogenic. Subclinical diabetes is unmasked and overt diabetes worsened. The degeneration of carbohydrate tolerance is most marked during the second and third trimesters. The risk of ketosis and acidosis is increased. There is an increased incidence of toxemia related to preexisting vascular disease. There will be a progression of complications such as nephropathy.
5. **EFFECT OF DIABETES ON PREGNANCY:**

   There is no impairment of fertility or increase in abortion rate in the adequately treated diabetic. The principal effects are upon the fetus which is liable to unexpected intrauterine death in the last weeks of pregnancy. At birth the infants are large, edematous and suffer from inadequate pulmonary ventilation. The infant must often be delivered prematurely. 2-3% of the infants have serious anomalies in the cardiovsacular or gastrointestinal tracts.

   The perinatal mortality is 10-15% in good clinics ranging from 5% in Class A to about 50% in Class D. The appearance of toxemia or diabetic acidosis markedly increases perinatal mortality.
6. **TREATMENT OF THE PREGNANT DIABETIC:**

   Care should be given concurrently by the obstetrician and internist. Class A: Diet, close supervision and delivery at or near term. A small daily dose of NPH insulin sufficient to maintain the postprandial blood sugar within normal limits (130 mgm % or less), will minimize the characteristic fetal changes in these patients.

   Class B, C, D, & E: All require insulin (oral hypoglycemic agents have not been accepted for use in pregnancy). The maternal insulin requirement increases and as a result more than one daily dose of insulin may be required.

   Diet must be constructed to permit a normal weight gain with reference to the patient's ideal weight (30 calories per kgm of ideal weight) and should contain a minimum of 1.5 gms/kilo of protein, 40% of the total carbohydrate and the remainder fat.

   Control should be such as to maintain fasting and 4:00 P.M. blood sugar below 130 mgm %.

   Hospitalization should be resorted to freely for the control of the diabetic state and any medical or obstetric complications.

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7. TIMING OF DELIVERY:
   The patient with Class A diabetes may be delivered at or near term in the absence of complications or an over large infant but should not be allowed to go beyond term.
   The patient with insulin dependent diabetes Class B, C, D, etc., should be delivered between the 36th and 38th weeks, either vaginally after induction of labor or by cesarean section. Prolonged induction should be avoided.
   Serial total urinary estriol output is one index of the integrity of the fetoplacental complex. Beyond 35 weeks, levels below 12 mgm. are unsatisfactory, and levels below 5 mgm., if confirmed, are considered critical.
   Nephropathy is an indication for therapeutic termination of pregnancy.
8. THE INFANT OF THE DIABETIC MOTHER: often delivered prematurely should be observed for the following:
   1. Respiratory Distress.
   2. Hypoglycemia (beginning about 2 hours after birth, commonly transient blood sugar level should be checked on cord blood and at 3 and 7 hours and calories given early by the oral or intravenous route).
   3. Hyperbilirubinemia.
   4. Hypocalcemia (stridor, tetany).
   5. Increased hematocrit with possible venous thrombosis.
   6. Increased incidence of major anomalies.

   Qualified pediatric supervision is a prerequisite to the care of the newborn of the diabetic mother.

ESTRIOL EXCRETION IN PREGNANCY

RATIONALE: Estriol excreted in the urine of pregnant women serves as a valuable indicator of fetal well-being. Estriol excretion reflects fetal status for two reasons: a) the bulk of maternal urinary estriol is produced by fetus and placenta, and the fetus is mandatory in estriol biosynthesis. b) Estriol transfer to the mother is rapid and virtually complete. The mother excretes estriol without major delay or further metabolism into the urine. Thus maternal urinary estriol excretion reflects truly and promptly its feto-placental production. Fetal distress and/or placental insufficiency cause a rapid decrease in estriol production, and estriol excretion drops without delay.

WHEN ARE ESTRIOL DETERMINATIONS HELPFUL?

Estriol determinations are helpful in any situation where fetal distress is suspected and termination of pregnancy might reduce the risk of intrauterine or neonatal fetal death. Normal estriol excretion indicates fetal well-being and allows the continuation of pregnancy, thus preventing unnecessary prematurity and reducing the risk of perinatal mortality.

Estriol excretion is routinely measured during the last 10 weeks of pregnancies complicated by DIABETES, HYPERTENSION, TOXEMIA and POSTMATURITY.

Serial estriol determinations are preferred since there are daily individual variations, largely due to fetal size. The larger the fetus, the more estriol is produced and excreted. Constant or increasing estriol excretion, checked twice weekly (or more frequently in certain cases) during late pregnancy when termination of gestation would be feasible, indicates good fetal development.

Extremely low estriol values indicate FETAL DEATH.

WHEN MIGHT ESTRIOL DETERMINATIONS BE MISLEADING?

1. In cases of RH-ISOIMMUNIZATION, urinary estriol determinations do not indicate hazards to the fetus.
2. Low estriol excretion might be found in cases of MATERNAL ADRENAL INSUFFICIENCY and ANENCEPHALIC BABIES, while the fetus does perfectly well.
3. MATERNAL KIDNEY FAILURE causes low estriol excretion despite normal estriol production by a well-functioning feto-placental unit. Plasma estriol determination may help in these cases.

METHODOLOGY

Urinary estriol is measured in the Gynecologic Endocrine Laboratory, Women's Hospital, University of Michigan Medical Center on 1% or 0.5% aliquots of a 24-hour urine collection. Radioactive estriol glucosiduronate is added before analysis to the urine. This is the form in which more than 90% of the estriol is excreted during late pregnancy. This addition of radioactive material permits correction for procedural losses. Our method eliminates any technical error and provides accurate, precise and specific results.

ACCURACY:	100.5% ± 2.2% recovery of estriol glucosiduronate added to 10 ml urine of a normal male subject.
PRECISION:	± 4.3% (Standard deviation).
SPECIFICITY:	The material measured is chromatographically pure.
TIME FOR ASSAY:	One working day = 8 hours.

NORMAL VALUES

The following table indicates normal values of estriol excretion during the 2nd half of gestation.

Weeks of Gestation	Estriol mg/24 hrs.	Weeks of Gestation	Estriol mg/24 hrs.
20	7	32	22
22	9.3	34	26
24	11.1	36	31
26	13.5	38	36
28	16	40	45
30	19		

HOW TO SEND SPECIMENS

Approximately 40 ml of a well-mixed total 24-hour urine collection are required. The result cannot be more accurate than the urine collection and the measurement of its volume ("total volume"). The Gynecologic Endocrine Laboratory supplies plastic containers and mailers upon request. The containers include a preservative. Mailing by "Special Delivery" is strongly recommended. When sent by special delivery, the specimens are usually received on the morning following the day they have been mailed. The results are given by telephone. Completion of the short questionnaire included in the mailers furnishes all information which is necessary for a useful interpretation of the results.

The Gynecologic Endocrine Laboratory
Uwe T. Goebelsmann, M.D.

MSMS, AMA Recommendations Offered Re Medical Society Acceptance of Federal Funds

Guidelines have been developed and approved by The MSMS Council for acceptance of federal funds by a medical society. The formal action by The Council is reported in the official minutes of The Council, outlining the following recommendations:

MSMS RECOMMENDATIONS

"One – That the Recommendations of the AMA Council on Medical Service as approved by the AMA House of Delegates be accepted as guidelines for MSMS policy. (The AMA guidelines follow)

"Two – That all programs involving direct use of government funds by component societies be presented to The Council, MSMS, for evaluation.

"Three – That information be obtained from other state or county medical societies who have established mechanisms such as a foundation, non-profit corporation, or other entity, separate from the society itself and served by independent administrative staff providing direct operational administration of government funds, without involvement of the medical society as a body, and that this information and the above guidelines be disseminated to component societies, and be a part of some early conferences of the MSMS."

These three recommendations now are part of MSMS policy.

AMA RECOMMENDATIONS

A Council on Medical Service report regarding medical society participation in government medical programs was adopted as amended by the House of Delegates. The Report set forth five recommendations providing guidelines to medical societies as follows:

"1. That this Association reaffirm past recommendations that state and local medical societies assume active responsible leadership in reviewing and setting standards for existing health services in their communities and in the evaluation, planning, developing, improvement, and augmentation of appropriate existing and new services.

"2. That this Association affirm the principle that state and local medical societies including federal funds, in conformity with recommendation #3 below, but only when such funds are essential for the society to maintain its proper role in the development of community health services and when formal agreements permit the society authority over the provision of medical care in accordance with the Principles of Medical Ethics.

"3. That this Association affirm that, in the continuance of its role of responsible leadership, a state or local medical society may enter into agreements with government agencies to administer health care programs and to have the administrative costs of such programs financed from governmental funds. The agreement must provide that such administration does not contravene the ethical precepts of the profession or interfere with the individual physician's freedom to exercise his professional judgment to protect the best interest of the patient. The society should use some mechanism such as a non-profit corporation or other entity, separate from the society itself, and serviced by an independent administrative staff, where possible, to avoid direct operational involvement of the medical society as a body.

"4. That this Association reaffirm its long-established policy that personal care is primarily an individual responsibility and that federal aid in financing care for those unable to pay should be provided only in conjunction with other levels of government – community, county and state. In individual situations, federal grants for research, demonstration, or pilot projects in methods of providing and financing health services may be permissible, but only under the condition that such new mechanisms, if found useful, be incorporated into the ongoing federal state-local programs for those in need, and, for those not in need, the usual private medical care financing methods were appropriate.

"5. That this Association point out that there are hazards to the medical society in involvement in government programs, whether at the developmental or the operational level, and that such involvement should be undertaken only after detailed study and review by the members of its potential impact. Any operational role undertaken by the society in such a program should be conditioned on the society's also having a voice in the planning, and any change in the society's role should be conditioned on prior review and consent by the society. Any contractual agreements entered into by the society, in regard to such programs should be for specific, limited periods of time, preferably not more than one year, and should be renewable only on agreement by the society."

ACTIVITIES, PROJECTS

Laboratory Facilities Council to Implement New Licensing Law

The Laboratory Facilities Council, a new advisory group to the State Department of Public Health, has been named in implementing a state law effective January, 1969 requiring the licensing of clinical laboratories.

The Council members are: Leo Walker, MD, Lansing; Harold Bowman, MD, Grand Rapids; Norman W. Arends, DO, Flint; Edna Andrews, PhD, Detroit; Arthur Jordan, M.S., Detroit; Robert Foy, PhD, Lansing; and Eugene M. Britt, PhD, Ann Arbor. The Council held its first meeting October 30 to review proposed rules under Act 235, P.A. 1968.

The Council's principal responsibility will be establishing rules setting up standards for licensing laboratories in and out of hospitals with the usual procedures of holding public hearings and legal clearances by the State Attorney General before adoption.

Rawling Serves Again As Vietnam Volunteer

John C. Rawling, M.D., Flint, is in Vietnam serving the civilian population through the AMA Volunteer Physicians for Vietnam program.

The two-month stay is a return visit for Dr. Rawling who worked in Vietnamese hospitals and also on the SS Hope hospital ship at Saigon during 1961. In the intervening time he has lectured and helped to raise funds for the medical-assistance program. He also made another trip aboard the SS Hope, serving in Trujillo, Peru, in 1963.

HUME, POMEROY LEAD ORTHOPAEDIC SOCIETY

Leaders of the Michigan Orthopaedic Society are H. Ross Hume, M.D., Detroit, president; Richard W. Pomeroy, M.D., Lansing, president-elect, and George Stilwill, M.D., Lansing, secretary-treasurer.

The officers were elected at the annual fall meeting of the Society in Detroit.

MSU, STATE HOSPITAL BEGIN JOINT PROJECT

An affiliation with Pontiac State Hospital providing for instruction of resident physicians and Michigan State University medical students has been approved by the MSU Board of Trustees and the state hospital.

Planned programs include field trips and summer extern programs for MSU medical students, exchange of residents in psychiatry, and faculty appointments for qualified members of the Pontiac staff.

Academic appointments in the College of Human Medicine will be offered to the medical superintendent and other qualified physicians on the hospital staff.

Leach, McClendon Honored by NAACP

J. Leonidas Leach, M.D., Flint physician for 46 years, and James J. McClendon, M.D., a practicing physician in Detroit for almost 40 years, were recently honored by the Michigan State Conference of NAACP branches. Both men are members of the executive board of directors of the National Association for the Advancement of Colored People.

Doctor Leach was cited for "his pioneering efforts for freedom, equality and civil rights as an early president of the Flint chapter of the NAACP and former president of the Michigan State Conference." Doctor McClendon received a similar citation for his long leadership of the Detroit chapter. Doctor Leach was the first Negro president of the Michigan Academy of General Practice. Doctor McClendon has been active in many civic organizations including the Detroit Metropolitan Area Regional Planning Commission, the Baptist Church, YMCA, and Booker T. Washington Business Association.

MSU ADDS REHABILITATION SPECIALIST FROM OHIO

John F. Lane, M.D., of Cleveland, has been named medical director of the Rehabilitation Medical Center in Lansing and associate professor of medicine at Michigan State University. MSU reports that Doctor Lane will play "a major role in the development of a model community program for the rehabilitation of stroke patients."

Doctor Lane has been a physiatrist and neurophysiologist with the Department of Physical Medicine and Rehabilitation in Cleveland's Highland View Hospital, and also an assistant professor of medicine and an associate in the Department of Physiology at Case Western Reserve Hospital.

Mary Jordan, right, Eaton Rapids, president of the Michigan State Medical Assistants Association, acccepts the state's first-place publication award in the "states with membership over 200" category from Wilda Haines, Canton, Ohio, awards chairman, during the American Association of Medical Assistants convention in Columbus.

X-Rays Show Transplanted Teeth Successful at U-M

Clinical tests and X-rays were described by oral surgeons at the University of Michigan School of Dentistry last month which showed that teeth have been transplanted successfully between related patients.

In the operation performed in February 1968 under local anesthetic, two bicuspids were extracted from 16-year-old Margy Batten and transplanted into the upper jaw of her 13-year-old brother, Bill, both of Elkhart.

The girl's bicuspids were impacted — and her brother's had never developed, so the transplant was attempted. For six weeks the teeth were held in place with stabilizing wires, much like a regular brace.

Now, eight months later, X-rays show that a new layer of dentin is being formed inside the pulp canal; new sockets have developed in the jaw; and both teeth are viable. A conventional pulp test indicates that the nerve supply is migrating into the new teeth.

James R. Hayward, D.D.S., head of dental oral surgery at the University of Michigan Hospital, said, "Although heterogenous tooth transplants (between different individuals) have been attempted for centuries, this may be the first instance in which the teeth survived with a viable pulp."

Unlike the heart transplants, immunosuppressive drugs were not used in the tooth transplant.

MEDISCENE

Dec. 11 – Eighth Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit

Dec. 11-13 – 14th Annual In-Service Training Conference, on Chronic Illness, Division of Adult Health, Michigan Department of Public Health, Holiday Inn South, Lansing

Dec. 18 – The Council, MSMS Headquarters, East Lansing

Jan. 20-24 – Michigan Cancer Foundation and American College of Physicians, "The Internist and Total Cancer Care," McGregor Memorial Center, Wayne State University, Detroit

Jan. 29 – The Council, MSMS Headquarters, East Lansing

Jan. 30 – State Woman's Auxiliary to MSMS, Board of Directors, MSMS Headquarters, East Lansing

Feb. 3-10 – Childrens Dental Health Week

March 12 – The Council, MSMS Headquarters, East Lansing

March 20 – Second Annual Cancer Conference for Nurses, Michigan Division American Cancer Society, Rackham Building, University of Michigan

March 20-21 – AMA Conference on Rural Health, Philadelphia-Marriott Motor Hotel, Philadelphia

March 26-27 – Eighth Annual Michigan Conference on Maternal and Perinatal Welfare, Pick-Durant Hotel, Flint

April 30 – The Council, MSMS Headquarters, East Lansing

May 7-9 – Michigan Public Health Association Annual Meeting, Pick-Durant Hotel, Flint

May 21 – Annual Muscle Symposium, Wayne County Medical Society Auditorium, Detroit

June 4 – The Council, MSMS Headquarters, East Lansing

July 13-17 – AMA Annual Meeting, New York City

July 31-Aug. 2 – MSMS Midsummer Session of The Council, Boyne Mountain Lodge, Boyne Falls

Sept. 28 – The Council, Sheraton-Cadillac Hotel, Detroit

Sept. 28-Oct. 3 – Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit

SOCIO-ECON

Prizes Awarded in State Contest for Best Hospital Money-Saving Suggestions

Employees of 25 Michigan hospitals recently shared $5,000 in cash awards in the Tenth Annual Search for New Hospital Achievements, cosponsored by the Michigan Hospital Association and Michigan Blue Cross.

The presentations were made during the annual Mid-Year Meeting of the Michigan Hospital Association House of Delegates at Traverse City.

The judges were faculty members from Michigan State University's College of Business and Human Medicine.

Selected to receive the Grand Award in this year's contest was Mrs. Jean C. Woelfel, a registered nurse from Bon Secours Hospital in Grosse Pointe. Mrs. Woelfel's description of the hospital's disaster control drills utilizing "live" victims stressed the importance of staff preparedness and immediate action during disaster conditions.

Special Awards for "Achievement Directly Related to Patient Care" went to: C. M. Kopp, M.D., director of clinical laboratories for W. A. Foote Memorial Hospital in Jackson; and Ben Hashemi, chief pharmacist at Children's Hospital in Detroit.

Honorable mention winners include: Robert Cole, Michael Ward and William J. Weber, M.D., of Ingham Medical Hospital in Lansing.

24-44 Age Group In State to Grow Fastest, 1965-85

Michigan's projected population growth is changing in the size of the various age groupings, so reports the U.S. Department of Commerce, Bureau of the Census.

The accompanying chart depicts the changing age structure over the period from 1965 to 1985. It is estimated the population will increase 30%, with the 25-44 age category growing the fastest at 50%, while the 45-64 age bracket will remain relatively constant by increasing just 6%.

These changes will create additional demands on our economy to fulfill the varying needs of the people. Housing must grow to meet the specific requirements of retirees as well as family-formers; services, both personal and public, will have to match; recreational facilities should be developed and diversified in a way to satisfy both "grandma" and the "teenage swinger."

Employment availability needs to expand to accomodate the growing size of the 18-84 age group. Educational demands will vary during this period between K-8, high school, and college requirements; and, finally, our senior citizens will require additional medical care and increased social security benefits in line with the 41% growth of this group.

In a recent opinion survey of Illinois physicians, 81% of those polled favored government grants to newly graduated physicians who agree to practice a certain number of years in medically deficient areas.

EMPLOYMENT FORECAST FOR MEDICAL AND OTHER PROFESSIONAL SERVICES BY REGION — 1960 and 1980

Region	1960	1980	Change in Number	Change in Percent
Jackson Area	9,744	29,000	19,256	198
Benton Harbor - St. Joseph Area	8,168	24,000	15,832	194
Kalamazoo - Battle Creek Area	20,748	61,000	40,252	194
Lansing Area	20,031	58,000	37,969	190
Flint Area	17,527	50,000	32,473	185
Traverse Bay Area	6,457	18,085	11,628	180
Saginaw Bay Area	22,984	63,200	40,216	175
Grand Rapids - Muskegon Area	32,572	88,915	56,343	173
Alpena Area	2,646	7,200	1,554	172
Eastern U.P. Area	4,186	11,000	6,814	168
Western U.P. Area	7,625	20,000	12,375	162
Detroit 7 County Area	177,232	439,000	260,000	147

Source: 1960, *Growth Patterns in Employment by County*, U.S. Department of Commerce, Office of Business Economics.
1980 projection made by economics staff, State Resource Planning Division

The Role of the Non Physician In Utilization Review

BY GORDON TAAFFE
CARL JOSEPHSON
BOTH OF MICHIGAN BLUE SHIELD

A complete medical record is an accumulation of a variety of documents pertaining to the medical care a patient has received as a consequence of illness, injury, or the prevention of illness. For hospital patients, the documents are generated by diverse departments and people within the hospital. For example, patient identification data, complaint, present illness, past history, clinical laboratory reports, and X-ray reports are some of the kinds of information that find their way to the medical record, also known as the patient's case history or as charts.

Upon discharge from the hospital, the Medical Records' Librarian catalogues the various source documents in the case history in an orderly fashion and files the history for future reference. Future reference may be review of the case history by a group of physicians in order to evaluate the quality of medical care the patient received while he was hospitalized.

Typically, in utilization review of medical care, a group of physicians review the contents of a case history for evidence of quality of medical care contained in the history. There is a legal precedence for such a review for Medicare patients,[1] and there is also professional interest[2] in utilization review for all hospitalized patients. For example, the American Medical Association[3] approved a resolution with respect to the objectives of utilization review: the review committee should "evaluate the quality of medical care on the basis of documented evidence to support diagnosis, treatment, and justified utilization of hospital facilities." The review process, however, is subject to considerable variability.

IN THE FIRST PLACE, present methods of selection of cases for review do not insure that all cases which need to be reviewed will, in fact, be selected for the utilization review committee. Selection of cases for review is often relegated to the Medical Records' Librarian, for example, who may pick out well-kept case histories rather than representative cases of typical or unusual patterns of medical care. The review committee may select its own cases but, with a large number of cases of varying complexity, it is difficult to select objectively all of the case histories which need to be reviewed.

In addition, highly specialized care may require the evaluation of a specialist for adequate review and members of some of the highly technical specialties may not be on the review committee. Individual differences among physicians create considerable variability in the quality and quantity of reports entered in the medical record. In this respect, traditional hospital-based utilization review is subject to inter-hospital variation.

ALTHOUGH INDIVIDUAL case review of medical case histories by a group of physicians is basic to utilization review, the non medical professional has much to offer in creating uniformity and objectivity in the review process. The systems analyst, for example, could define precisely what information is needed in the case history that is both necessary and sufficient for an adequate review of that history. The operations researcher could determine parameters of medical care and objectively select case histories that depart significantly from the parameters.

Data accumulated by a prepaid group health insurance agency affords a broadly based utilization review system that would permit reviewing variability between hospitals and at the same time include home and office care with inpatient stay. A broadly based computer-assisted utilization review program would release the review physician from many time consuming administrative aspects of reviewing case histories and at the same time

The reluctance of the physician to become involved in utilization review probably is due to a variety of reasons. Of these, the most important is his concern that it is another job that he doesn't have time to do. The purpose of this article (the fifth in a series on Utilization Review) is to show that the busy, dedicated physician doesn't have to do it alone; in many ways the non-medical professional can be helpful.

—Louis F. Hayes, M.D.
Vice President, Medical Affairs
Michigan Blue Shield

give the opportunity for objectivity in selecting all cases which need review.

All cases needing review would be brought to the attention of the review physician through a computer-assisted review system based on parameters of medical care.

A DIVERSE GROUP of non medical professionals would be needed to implement the utilization review program outlined above. Data processing specialists, for example, would be key personnel to the system. Developing parameters of medical care based on length of stay, costs, and procedures for particular diagnoses and medical conditions is a highly technical problem. Statisticians and operations researchers would cooperate on this developmental aspect of the program. Computer identification of cases for review would be the first objective of this review program.

A by-product of the identification process would be a listing of selected cases with community standards for comparable cases. Secondly objectives would be a preliminary screening of selected cases prior to review. In this way, the review physician would not only have case histories whose records depart in some particular from standard medical practices, but he would also know what the standard is.

Although quality of care is evaluated against medical criteria, indexes of typical care are available to review physicians from a variety of non medical sources. Vital statistics, for example, provide much "base line" information about births and deaths in the general population as well as figures on the incidence and prevalence of diseases. The rapidly burgeoning field of medical economics is amassing data about the organization, administration, and delivery of medical services.

Medical economics is concerned with the costs of providing care and also with values received. Not only is medical care being evaluated in terms of surgery, laboratory services, drugs, length of hospital stay, and other strictly medical problems, but also health services are being considered with respect to cost-benefit analyses, patient satisfactions, type of practice, allocation and distribution of medical services in relation to demand for these services and many other aspects of the medical system. White[4] states "the term 'quality of medical care' has unfortunate pejorative connotations. It assumes, first, that there are objective methods for distinguishing 'good quality' from 'poor quality' care and, second, that there are a substantial number of physicians who much of their time do less than their best work." White suggests that the incidence of incompetence among physicians is low but that the circumstances under which a particular physician works can lead to inefficiency. Many standards and evaluative indexes of medical care can be derived from non medical disciplines. That is to say, those things contributing to the organizational efficiency of medical services and to the sociological and psychological evaluation of the end product of medical care can come in part from non medical personnel.

THE CONTRIBUTION OF THESE non medical personnel is distinct from the medical contribution but is relevant to the overall efficiency of the medical system. In summary, non medical personnel in utilization review can contribute to:

1. Uniformity and standardized medical records.

2. Development of computer-assisted techniques for identification of medical records in need of review.

3. Development of computer-assisted techniques for preliminary medical evaluation of patient care.

4. Assessment of community patterns of patient care.

5. Assessment of community attitudes and behavioral patterns toward medical problems.

6. Efficiency in the organization, administration, and delivery of medical care.

7. A broadly based utilization review system.

REFERENCES

1. Public Law 87-89, 89th Congress, H.R. 6675, July 30, 1965.
2. *Utilization Review: A Handbook for the Medical Staff.* American Medical Association, Chicago, 1965.
3. Op. cit., p. 9-11. "The Utilization Committee is a fact-finding, educational instrument of the medical staff . . . (that) devotes particular attention to . . . unnecessary admission, excessive length of in-patient stay, delay in use or over-use of X-ray, laboratory and other diagnostics and therapeutic services, and delay in referral."
4. White, Kerr, "Research in medical care and the health service system." *Medical Care,* Vol. 6, No. 2 (March-April 1968) pp. 95-100.

State Official Serves On HEW Grants Committee

Serving on the 18-member Grants Administration Advisory Committee of HEW is Paul H. Wileden, Director, Budget Division, Executive Office of the Governor, Bureau of the Budget of the State of Michigan.

The committee comprises eight members of the Department of Health, Education and Welfare and 10 public members who are involved in health, education and welfare programs in State Departments and State budget offices, public and private universities and hospitals, medical schools and private non-profit foundations.

LARYNGEAL NERVE DAMAGE IN THYROIDECTOMY

(Editor's Note: The following article is quoted from the AMA Citation newsletter of October 15, 1968, prepared by the AMA Law Department.)

A patient suing a physician for laryngeal nerve damage suffered in a thyroidectomy may rely on the physician's own testimony on the standard of care in order to establish a *prima facie* case of professional negligence against him. Setting aside a directed verdict for the physician, a Michigan appellate court remanded the case for a new trial on the issue of negligence in the performance of the operation. The court further held that there was no jury question as to the physician's alleged failure to obtain the patient's informed consent.

The patient had a normal woman's voice before the operation was performed in March, 1957. The physician noted during the operation that her laryngeal nerves were normal in appearance. After the operation, her voice was hoarse, rough, and harsh, and much different than it had been before the operation. The physician told her that the condition would clear up. However, the condition allegedly persisted until the time of the trial, nine years after the operation.

GEO. CRENSHAW

"Let me know if this prescription works. I'm having the same trouble myself."

The patient consulted a second physician sometime after the operation. He diagnosed her condition as laryngeal nerve paralysis. That diagnosis was confirmed by physicians at two hospitals.

The physician testified that, although the laryngeal nerves are within the field of operation in a thyroidectomy, the nerves can and should be avoided. Since he had performed more than 100 thyroidectomies prior to the one involved here, he was qualified to testify as to the accepted standard of care in the community in the performance of a thyroidectomy, and the patient could rely on his testimony in attempting to establish a *prima facie* case.

Moreover, there was expert medical testimony tending to show a violation by the physician of his duty to avoid injuring the patient's laryngeal nerves, although such testimony was not as explicit as is desirable. While the patient's medical expert did not state that the patient's laryngeal nerve had been cut during the operation, he did state that there was an injury to the nerve that was attributable to the operation. In view of that evidence, a verdict should not have been directed for the physician.

There was, however, no jury question as to the physician's alleged failure to obtain the patient's informed consent to the operation. Whether a physician should, before operating, advise the patient of all possible results, so that he may intelligently give or withhold consent to the operation, depends on the accepted practices in the community. The patient testified that the physician did not explain anything about the thyroidectomy prior to its performance. However, there was nothing in the record to show that it was standard practice to discuss the possibility of laryngeal nerve injury. The physician testified that the patient was told what to expect by way of results. However, when, as here, the result is unexpected and caused by an allegedly negligent act, the lack of informed consent cannot be proximately related to the patient's injuries. — *McPhee* v. *Bay City Samaritan Hospital,* 159 N.W.2d 880 (Mich., March 29, 1968; rehearing denied, May 28, 1968)

from Vol. 18, No. 1

Physicians Can And Do Help Make State Laws

BY M. A. (MIKE) RILEY
MSMS LEGISLATIVE COUNSEL

On January 8th, 1969 the 75th Michigan State Legislature will swing into action in Lansing and, within a few weeks, organize itself and establish deadlines for the processing of approximately four thousand proposed bills during its two-year tenure.

It can reasonably be expected that well over 200 of these proposals to be made in 1969 and 1970 will suggest important new laws, or important amendments to existing laws, in the medical practice area. Perhaps an equal number of bills will relate in some way to the broader classification of "health care."

CLEARLY, THE MEDICAL profession has ample cause to take an active interest in the legislative process, since such a significant proportion of the matters considered by the State Legislature directly affect the practice of medicine and thus the quality and cost of care.

By the time of final adjournment of the Michigan Legislature in 1970 several scores of health law amendments or completely new laws will have been added to the statute books.

Every citizen of Michigan CAN have an impact on the decisions of the State Legislature, and this is particularly true in the case of doctors of medicine, because health legislation is nearly always technical in nature and those who must pass upon it genuinely require, and appreciate, the informed viewpoints of professionals.

Yet, no citizen, physician or non-physician, can have an impact upon the legislative process unless he avails himself of the means at his disposal to participate in that process. At times, of course, lawmakers will seek out public opinion (through polls, questionnaires, and the like) but far more frequently the bulk of opinion on a given proposal which is expressed to legislators comes to them through the initiative of the interested party.

WHEN A VITALLY important health law is under legislative consideration, therefore, which affects every citizen it should be expected that each lawmaker WILL hear from many people — people who take the time and trouble to write to him, wire him, telephone him, or actually visit with him either in his home area or in the State Capitol. Many people WILL avail themselves of the various means at their disposal to express their views. *Vis-a-vis* the vitally important health proposal, it is obviously desirable that many of those who express opinion are physicians.

Without belaboring the point, since doctors of medicine are by no means a majority of the general population, and since health legislation increasingly interests more and more people, the absolute NECESSITY for physician liaison with lawmakers is all too clear. All of the physicians in a community may concur in the inadvisability of a proposed health law, may discuss it among themselves at medical meetings, in the hospitals and in chance social gatherings — but they will have no impact whatsoever on the State Legislature unless they convey their views to their elected representatives. Meanwhile, a mere 5% of the general community (which may numerically outnumber the physicians ten to one) may actually be importuning those representatives to PASS that objectionable law.

SINCE THE LEGISLATOR'S job is to represent, to the best of his ability, all of the people of his constituency he is not to be faulted if he does not have the opportunity to weigh the views of those who are really best qualified to advise him. Neither is he to be faulted for failure to seek out professional opinion, for he has not one or two, but perhaps hundreds of proposed bills on scores of subjects to consider.

LOBBYING

The Michigan State Medical Society employs staff personnel to act as an operating arm of the Society's Legal Affairs Committee which, in turn, is advisory to The MSMS Council. A "lobbyist" is one who is paid to legislatively represent a group or a position. In the case of proposed health legislation, the members of the State Legislature WILL hear from MSMS' representatives in Lansing and, as the exception rather than the rule, they will also hear supporting, or sometimes conflicting, views from a large number of "lobbyists" who represent other health-related groups, other professions and other organizations.

"Lobbyists" are essential to the legislative process, a fact now universally accepted. Their activity is legally recognized and legally regulated, and for the most part is carried on forthrightly and respectably. They are frequently recognized by lawmakers as experts in the particular area of interest of their employers, and THEY are frequently sought out by members of the Legislature for technical information. They must, if they are to be effective at all, have a reputation for honesty and dependability.

The "lobbyist," moreover, exercises effectiveness dependent upon the reputation and expertise of his employer. Since the medical profession indeed enjoys the very highest order of respect, its representatives in the Legislature are privileged to benefit from the high regard in which lawmakers hold their employers.

No lawmaker in Lansing would PREFER to receive his information on a technical medical matter from the "lobbyist" rather than from his constituent physicians back home. If he does not have an open channel of personal communications with doctors of medicine, however, there is still an avenue open to him in his workshop in Lansing to ascertain medical opinion. The "lobbyist" WILL seek him out, and alert him to matters of great interest to the medical profession.

Thus there are two mechanisms simultaneously in operation, each of which complements the other — day-to-day representation in the Capitol itself by the "lobbyist," and person-to-person contact between physicians and their own legislators in both the home areas and the Capitol itself. Neither is a substitute for the other, and between the two it is the latter which is indispensable.

WE CAN, AND DO, ALL HELP MAKE OUR LAWS — and we have a very real choice in outcomes. We can help to make them good ones by realizing that our elected representatives ARE accessible and DO welcome constructive contact. We can all help to make our laws bad ones by simply not participating in the process.

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Let's Abolish Criminal Insanity

BY STATE REP. ROY SMITH, CHAIRMAN,
SPECIAL COMMITTEE ON MENTAL HEALTH
LEGISLATION FOR CRIMINAL CASES
OF YPSILANTI

The theory that the insane person should not be held responsible for his crimes, that "the madman is punished by his madness alone," appears to be universally regarded, by lawyers and laymen alike, as one of the great enlightened principles upon which our system of justice is based.

As a layman who has recently, in conducting an extensive legislative study, been privileged to discuss related specific questions with some of the best psychiatric and legal authorities available, I question this age-old, time-honored theory, for two reasons:

First, I see little evidence, in either our laws or the level of financial support we give our mental institutions, that we have ever really believed this principle.

Second, even if we did believe it, I wonder if this theory isn't inherently unworkable?

LET'S LOOK, FOR EXAMPLE, at the plea and verdict of "not guilty by reason of insanity." The best-known example I could cite of the popular concept of how this verdict works would be the novel *Anatomy of a Murder,* which was written by a former Michigan Supreme Court Justice, under the pen-name of Robert Traver. Most everyone who read that great best-seller of 1958, or saw the Otto Preminger movie made from it, was probably left with warmly-renewed faith in our legal system.

In this story, it may be remembered, a cool-mannered Army lieutenant killed the man who had raped his wife, then insisted in court that he could remember nothing of the shooting. Considerable doubt was cast on his story, but this didn't matter. The jury, like the reader, wanted to see the lieutenant acquitted. And the insanity verdict by offering a means of freeing him proved its wonderful and enduring value, even if occasionally misused.

Although reportedly based upon an actual case, there is one troublesome flaw in the picture painted by this story: under a Michigan statute that was repealed only in 1966 (P.A. 175 of 1927, Sec. 766.15C), any person found not guilty of murder by reason of insanity had to be committed to an institution for the criminally insane — not until found to be sane but, unless a governor intervened, *for the remainder of his natural life!*

MEANWHILE, THE AVERAGE person found *guilty* of murder appears to have been serving about 15 years in prison.

If the kindly old judge in *Anatomy of a Murder* had followed the law, as real-life judges generally do, the lieutenant would not have been freed. Instead, he'd have stayed on in a county jail for months, waiting for overcrowded Ionia State Hospital to admit him. His first glimpse of his future home would probably be somewhat reassuring; he'd see no fence or wall around the buildings, nothing to suggest a prison.

Once inside, though, he'd soon wish there was a wall. When hospitals are forced to serve as custodial institutions, a certain price has to be paid. Wherever the lieutenant went, from the oppressive monotony of the wards to the rushed schedule and ear-splitting din of the big barn-like dining-room, he'd move through portions of the seemingly endless tunnels that honeycomb the place.

Even on a mere tour of Ionia, an official Medical Audit Committee reported after a 1965 study, "one begins to feel somewhat like a mole."

Because of a shortage of both linens and clothing, the lieutenant would have been allowed to take just one shower a week, or two showers if he performed manual labor. To add to the smell of sweat in his crowded ward at night, he'd have been forced to use what is politely termed a "chamber pot," for which no cover was provided.

All of which, as the Audit Committee noted, "results in quite an odorous situation . . . since ventilation is a problem in some areas."

Still, the lieutenant would have found the most unbearable aspect of his confinement to be sheer monotony. "The absolutely apathetic, empty existence that these men lead on the wards and the groping efforts which they follow to busy themselves with nothing is terrible to behold," the Audit Committee reported. And the House Men-

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The author, Representative Roy Smith, of Ypsilanti, has been chairman of a special committee of the Michigan House of Representatives to study mental health legislation for criminal cases. Representative Smith, a graduate of the University of Michigan and a former Ypsilanti Township supervisor, was first elected to the Michigan House in 1966.

tal Health Committee, conducting its own study, concluded that "Hopelessness is more apparent than treatment."

IT IS NOT MY PURPOSE to condemn Ionia State Hospital, where conditions have been improved in the last two years, and which is in the process of being phased out as a special institution for the criminally insane anyway. Conditions would have been far more unbearable in 1965, the Audit Committee noted, except for the constant and determined efforts of a number of dedicated staff members.

Moreover, the place where Michigan has been confining its criminally insane was no worse than St. Elizabeth's in the District of Columbia or Matteawan in New York State, and all three are better than most such institutions in this nation. As one professor of psychiatry, Dr. Emanuel Tanay of Wayne State University, writes me, "The hospitals for the criminally insane across the country are neither hospitals nor jails, but combine the worst of both!"

This nation spends an average of $6.30 a day on inmates of its public mental institutions — in an era when any semblance of true psychiatric care in a private hospital runs at least $50 a day. As a result, according to one nationally-known legal expert, Professor B. J. George, Jr. of the University of Michigan, confinement in such institutions "is difficult to distinguish from penitentiary imprisonment, except that the penitentiary is likely to offer more rehabilitation services than the mental institution!"

IN LIGHT OF THIS, and in light of the fact that the special institutions for the criminally insane have almost invariably been the oldest, most remote, and least desirable of our mental hospitals, can we really go on pretending that we are relieving the insane of criminal responsibility, that we are allowing the "madman" who is charged with a crime to be punished by his madness alone?

AUTHOR
REP. ROY SMITH

Most often, we deny such persons their day in court by ruling them "mentally incompetent to stand trial." In other cases, we grant them a trial and find them "not guilty by reason of insanity" — a verdict that has the practical effect of meaning "guilty and insane." The end product of both procedures is that we punish the "madman" doubly — by confining him indefinitely rather than for a specified term, and by confining him in a place that is generally no better than prison and is frequently worse. Then we doubly damn him by branding him "criminally insane!"

Most of the patients of Ionia, and at New York's Matteawan and other such institutions were committed as "incompetent to stand trial" — which means their confinement resulted neither from having been convicted of a crime nor having been ruled insane in the formal hearing of a civil commitment procedure. In other words, it would be no exaggeration to say that most of our so-called "criminally insane" have not formally been ruled either criminal or insane by any semblance of due process of law.

Dr. Ames Robey, who heads Michigan's new Center for Forensic Psychiatry, has made an extensive study of the question of incompetency and has asserted, in the *American Journal of Psychiatry,* that the widespread misuse of this procedure "represents the grossest violation of an individual's rights." Yet if past precedence is any guide, as another study, made at Ionia, summarized its statistics in the same *Journal,* "well over half the individuals committed as incompetent to stand trial will spend the rest of their lives confined!"

I ASK AGAIN, CAN WE really claim the "madman" we charge with a crime is being punished by his madness alone? Since 1939, we have had, in Michigan, a law I hope to see repealed in the current Legislative session — a "criminal sexual psychopath" statute providing for the commitment of certain persons charged with or convicted of sex crimes. In examining the workings of this law, a Governor's study commission discovered that, as a rule, the major and violent sex offenders were being sent to prison while the minor or nuisance offenders were being committed to a mental institution. Yet the same study showed that the sex criminal imprisoned at Jackson was twice as likely to be paroled, within any given number of years, as the offender committed to Ionia!

I make no claim to either legal or psychiatric expertise. But to my layman's mind, we have a "gray area" in our system of justice — a zone where our courtroom procedures are not really criminal or civil in nature, where confined persons are not really patients or prisoners, and where places of confinement, as Dr. Tanay put it, "are neither hospitals nor jails." And in my layman's opinion, this gray area exists only because we are stubbornly refusing to face up to one very basic question:

HOW, IF INSANITY RENDERS a person not guilty of crime, can anyone possibly be "criminally insane?"

The word "insanity" has no real medical meaning. Psychiatrists refer to it as "a vague legal term for mental illness." Courts define it only by means of statutory "tests." Originally, for example, there was the old English M'Naghten Rule: Did the accused know right from wrong? At present, the Durham Rule is used in some jurisdictions: Was the crime a "product" of mental illness? Still another test, recently proposed for Michigan, read as follows: Was the accused, at the time he acted, incapable, by reason of mental disorder or defect, of conforming his conduct to the requirements of the law?

Such semantic gymnastics could be performed indefinitely. But Dr. Alexander Dukay, who heads Ypsilanti State Hospital, has expressed doubts to me that any statutory test for substantive insanity will ever really prove satisfactory. All such tests ask a question that can seldom really be answered yes or no. In actual practice, in fact, the question is usually answered both ways; both the defense and the prosecution generally manage to find psychiatrists to support their respective arguments.

The very concept of a legal test for insanity in a criminal case, it seems to me, is based upon the highly questionable assumption that we can invariably draw a line between a non-responsible group for whom commitment is indicated, and a blackhearted bunch who deserve to go to prison.

Even if we were living up to that assumption by providing the insane with conditions of confinement far preferable to those offered convicts — and we are not — the assumption would still be highly questionable. I think I can safely assert that even the most hopelessly psychotic person generally retains some measure of volition or choice. And after discussions with such experts as Dr. Andrew Watson, who has the rare distinction of being a professor of both psychiatry and law at the University of Michigan, I feel similarly secure in asserting that most criminal acts are at least partially the product of some degree of mental disability. The sharp, clear dividing line demanded by the statutory tests for substantive insanity simply doesn't exist.

I THINK MICHIGAN HAS moved far ahead of most states toward recognizing this fact. In addition to initiating the phasing out of Ionia as a special institution for the criminally insane, the 1966 Legislature made many statutory gains — including a new law covering mental incompetence that probably provides more safeguards than any other in the nation today.

I hope the present year will see Michigan making a definite beginning on the construction of a proposed new "twin" facility, where the departments of Mental Health and Corrections can work cooperatively and yet in their separate fields of expertise, providing competent treatment in a setting of secure custody for both mentally ill convicts and mental patients who present security problems.

The day when psychiatric treatment will be regarded as a major and indispensable part of prison rehabilitation efforts, with adequate financial support, may be far in the future. I do not propose, no matter how extensive past abuses have been, that we can eliminate the major commitment procedures that occur in our criminal courts — incompetency-to-stand-trial rulings, and not-guilty-by-reason-of-insanity verdicts.

I do suggest, however, that the time has come for us to recognize clearly that our public mental hospitals are medical and not custodial institutions, that the very dedicated psychiatrists who staff them are doctors and not wardens, and that we have no right to make them responsible for the confinement of any individual except for the purpose of providing care and treatment. In other words, we must stop burdening our Department of Mental Health with persons who are more properly subjects for conventional criminal sentencing.

WITH THE ADVANCES made in 1966, Michigan has reached the point where the entire contradictory concept of the so-called "criminally insane," including such resulting designations as "criminal sexual psychopath," can be erased from the lawbooks and the language alike, and patients in our mental hospitals can be regarded solely as sick people, without criminal stigma to discourage recovery. If repeal of the outdated criminal sexual psychopath act can be achieved this year, in fact, the remaining task will be more one of education and adequate financing than statutory change.

Only when we stop looking upon our mental institutions as an auxiliary prison system can we really claim to be relieving the insane of criminal responsibility. Both the laws and the living conditions with which we have been doubly punishing "madmen" are the products of our pretensions. I urge only that we discard those pretensions.

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Nixon's Views on Medical Issues

Richard M. Nixon will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues: —

FEDERAL ROLE IN MEDICINE

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

MEDICARE

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a re-examination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

MEDICAID

I favor the basic philosophy of medicaid — that of helping medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations . . . .

What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

NATIONAL COMPULSORY HEALTH INSURANCE

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need . . . .

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

COMPULSORY AREAWIDE HEALTH PLANNING

I oppose compulsory areawide health planning. We can't assure communities better health planning just by making such groups compulsory. Areawide planning should be left to state and local determination.

FEDERAL CONTROL OF PHYSICIAN'S FEES

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

DEPARTMENT OF HEALTH

As President, I intend to establish a Commission on Government Reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

MENTAL HEALTH

We must develop new methods of treating the mentally ill . . . .

TAX DEDUCTIONS FOR THE AGED

The 100 percent income tax deduction for nonreimbursable drug and medical expenses of those over 65 should be restored.

PREVENTIVE MEDICINE

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.

Automated mass screening programs would seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

HILL-BURTON ACT

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered.

ABORTION LAWS

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state . . . . I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state — a majority of people of the state — reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered.

SIDE EFFECT

A drug is a substance which, if injected into an animal, produces a paper.

—Otto Loewi, Ph.D., *quoted in IBM Think*

IRON MOUNTAIN SALUTES NATIVE ON COLUMBIA STAFF

William B. Seaman, M.D., chairman of the radiology department of the Columbia University College of Physicians and Surgeons, recently returned to his home town of Iron Mountain for a "Native Son Appreciation Day" celebration in his honor.

Three local doctors were speakers at the dinner program sponsored by the Rotary Club and attended by several hundred citizens of Iron Mountain. John Newkirk, M.D., W. H. Huron, M.D., and Donald Anderson, M.D., described Dr. Seaman's early life and professional career.

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Midwest Health Care Conference Proposes Many Suggestions

BY VERNON V. BASS, M.D.,
SAGINAW, VICE-SPEAKER OF
MSMS HOUSE OF DELEGATES

The recent midwest Conference on Health Care offered a number of suggestions which might prove helpful to medicine, hospitals, business, government and other segments concerned with the subject.

The Secretary of HEW sponsored a Regional Conference on Health Care Costs recently in Cleveland. Twenty-four representatives of the medical professions, hospitals, insurance, labor, nursing, and public health attended from Michigan.

Many of the comments are worth reporting and interpreting for MSMS members; and it must be recognized that such possible articles could take many different approaches.

HEW Secretary Cohen set the tempo for the conference with this quotation:

"The Conference has been designed to bring together the leaders of the health community and the insurance industry, consumers and purchasers, (both government and private) to approach the problem of rising health care costs through the stimulation of experiments and innovations in the organization and delivery of health care services, as they relate to state and local communities."

THE OPENING ADDRESS by George Bugbee, director, Center for Health Administration Studies, University of Chicago, who expressed serious concern about rising costs, technological changes, inflation, hospital payrolls, MDs fees, and a hope for innovative ideas at the local community to halt rising costs.

Arthur E. Hess, Deputy Commissioner, Social Security Administration, then described problems "to promote and emphasize voluntary effort and action." He said, "local control often means no control and no planning." He asked the participants to "explore the public and private policy of providing health care so that the consumer can get dollar value." He emphasized the importance of health care delivery and "the judicious combination of peer groups and incentive formulas and methods to provide better efficiency in the delivery of health care."

The conference participants met in discussion groups and then presented observations and recommendations.

Representing MSMS at the Midwest Conference were Vernon V. Bass, M.D., Saginaw, Vice-Speaker, MSMS House of Delegates; Robert E. Rice, M.D., Greenville, Chairman, MSMS Committee on Rural Medical Services, and also Herbert Mehler, of the MSMS Staff.

THERE WAS CONSIDERABLE discussion about hospital costs. It was recognized that "with about 75% of hospital cost going for personnel, how real is the cost control that the physician can exert?"

The most effective system of cost control, it was suggested, will come through a partnership effort, whereby the board, the administration, the medical staff, and other staff are collaboratively engaged in reaching the dual objectives of (1) quality service to the patient, and (2) control of costs. Cost control is achieved by a variety of means, such as non-duplication of expensive equipment, fullest possible use of facilities, wise deployment of personnel, rendering of services by the most efficient means, etc.

As a means to achieve this partnership effort, it was proposed that:

a. Physicians serve on the governing boards of hospitals with the same privileges as other board members;

b. Hospital medical staffs be given the opportunity to select their representatives to the board, be careful in the selection, and see that there is provision for continuity on the board;

c. Opportunities be provided whereby administration and medical staff, and other staff, get together to explore and work out more effective ways to achieve common objectives, especially the objective of quality patient care coupled with cost control.

(Continued on 1527)

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

350-8

Many, many needs were expressed in the reports from the discussion group. These included:

1. Simplify paper work in Medicare-Medicaid
2. Use medical students in doctors' offices
3. Education of consumer to conserve health
4. Medical schools should provide medical economic courses for medical doctors
5. More use in ECF's of home care services
6. Improve productivity through better management
7. Commercial carriers should have more rapport with medical societies
8. Funding to facilitate use of more medical advertising and marketing to advise people of available health services
9. Improve recordkeeping — need for data banks
10. Centralization of emergency and weekend services
11. More use of lower level para-medical personnel
12. Further standardization of nomenclature and coding
13. Education of the consumer to keep costs down
14. Education of consumer that medical care is not free
15. Immediate expansion of medical schools
16. More use of para-medical personnel before MD sees patient

Many materials were distributed to the conference participants. Copies are available for interested MSMS members who write MSMS, 120 West Saginaw, East Lansing 48823, for any of the following:

The following material is available on request:

1. "A Health Screening Program for the Inner City: — Flanner House of Indianapolis
2. "Community Health Foundations" — Cleveland, Ohio
3. "Controlled Charges, Reimbursement and Hospital Costs" — Indiana Hospital Association, Indianapolis, Indiana
4. "Expanding Community Hospital Services: Progressive Patient Care" — presented by Robert DeVries, McPherson Community Health Center, Howell, Mich.
5. "Illinois Study Committee on Nursing (ISCON)"
6. "Comparable Costs and Economic Feasibility of the Illinois Zone Mental Health Program" — Illinois Department of Mental Health
7. "Responsibilities of Private Insurer for Experimentation with Methods of Providing Health Care" — Nationwide Insurance Company, Columbus, Ohio
8. "San Joaquin Foundation for Medical Care Prepayment Pilot Project"
9. "Selected Activities of the Chicago Hospital Council Relating to Quality of Care and Cost of Care," Chicago Hospital Council.
10. "Shared Computer Program," Mt. Sinai Hospital, Milwaukee, Wisconsin.

BOOKLETS SUGGESTED TO HELP PLAN HEALTH EDUCATION EFFORTS

Public Affairs Committee booklets on many social and health problems are available to help physicians and county medical societies develop projects, speeches, TV and radio programs, etc., in many areas of current concern.

The Public Affairs Committee is a nonpartisan, non-profit organization in New York, which was founded in 1935 "to help educate the American public on vital economic and social problems."

A note to the Committee can request a copy of their current catalog, or can help interested physicians obtain specific booklets for 25 cents each.

SMOKING-HEALTH

"Smoking, the Great Dilemma," pamphlet no. 361.

"It's Not Too Late to Stop Smoking Cigarettes," no. 386.

"Cigarettes and Health," no. 220A.

SEX EDUCATION

"How to Tell Your Child About Sex," no. 149.

"Sex and Our Society," no. 366.

OTHER TOPICS

"The Negro in America," no. 95.

"The Delinquent and the Law," no. 337.

"What We Can Do About Drug Abuse," no. 390.

"Fads, Myths, Quacks — and Your Health," no. 415.

Mailing address for the Public Affairs Committee is 381 Park Avenue, South; New York, New York 10016.

> "No physician insofar as he is a physician, considers his own good in what he prescribes, but the good of his patients; for a true physician is also a ruler having the human body as a subject, and is not a mere money maker."
>
> — Plato

Michigan Pharmacy Spokesman Asks His Members, "What's Ahead?"

BY ROBERT C. JOHNSON
EXECUTIVE DIRECTOR
MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

REPRINTED FROM MICHIGAN PHARMACY JOURNAL

We are just four days away from completing another fiscal year, the 85th in the Association's history.

How many of these previous eighty-five years were fraught with critical problems that confronted the profession, I do not know. One thing I am certain of is that the problems and challenges that face us will not diminish in the future. If anything, we can expect an even greater test of our profession's strength and ability in the years ahead.

All too many pharmacists continue to have the opinion that they can go it alone — they do not recognize that the conditions which exist in society today are of such magnitude that no individual can possibly cope with all of them.

IF PHARMACY HAD no professional society to represent it, certainly, one would have to be created today.

Government, for example, would not take the time to consult with each individual pharmacist relative to any program that it intended to initiate — but government will listen to a representative body of the profession. Granted, they may not accept every request or recommendation that the association may propose, but, nevertheless, they will listen and, certainly, it has been our experience that many of our proposals have been acceptable.

Try to think for a moment what the practice of pharmacy might be today if there had been no association to speak in its behalf. Would pharmacy as a profession even exist today?

Pharmacy, even with representation, has been, to a considerable extent, a captive profession — captive of the physicians and captive of the pharmaceutical manufacturers. The right to exercise true professional judgment has been impinged since the demise of the era of compounding. Instead, the pharmacist has been compelled to dispense the manufacturer's brand name of a drug as written by a physician. This has left little opportunity for the pharmacist to utilize his highly skilled professional training.

Pharmacists are growing tired of this captivity — and properly so.

PHARMACISTS ARE beginning to ask

— *With my education, why shouldn't I be playing a more responsible role on the health team?*

— *Why shouldn't I be determining the patient's medication regimen?*

— *With my knowledge of drugs, why shouldn't I be determining the drug or brand of drug that should be prescribed?*

— *Am I not in a position to relieve the physician of certain of his responsibilities that he is finding less time to assume?*

These same questions are beginning to be asked by even those outside of pharmacy. With the changing patterns of health care that are developing, government officials, as well as those more enlightened members of other health professions, are wondering why the pharmacist is not performing certain functions that he is trained for but, because of tradition, are still being performed by the physician.

THESE QUESTIONS MUST BE answered and let me assure you that your professional associations, both APhA and MSPA, are directing their attention to these matters with the hope of finding the solution in the very near future.

All informed individuals will admit that the delivery of health care in this country leaves something to be desired.

Certainly, we do not want to develop a completely socialized system that would deprive the citizen of his right to select his health care providers. At the same time, we want to recognize that health care is not a privilege but a *right* to which everyone is entitled.

As pharmacists and responsible health professionals, we must seek ways by which we can better

Editor's Note:

Today medicine is being buffeted on all sides by experts in the field of medical care. In spite of all the experts, the individual care of patients remains the responsibility only of the physician, on a legal, moral and ethical basis. The very basis of medical care is that of therapeusis (the patient does not care much about diagnosis but is most interested in cure). We wonder if the views expressed by Mr. Johnson represent those of the pharmaceutical profession and how they affect a relationship based on years of progress together. The italicized words are mine and not the author's.—John W. Moses, M.D.

deliver our services to the patient and better serve the total health needs of a community — making certain that every citizen is properly cared for.

COMMUNITY PARTICIPATION NEEDED

For any pharmacist to say that he does not have time to participate in community health programs is an admission that he is shirking his responsibility to society.

For years we have been talking about our individual responsibility to the profession which by now, I trust, is well accepted by everyone. I think *now* is the time we must place our emphasis on our responsibility to society.

Society has provided us with our education and with the opportunity to practice our profession. We then must return to society all that we can possibly give to provide a better, healthier environment in which to live.

Certainly, this is a sick world — one that needs the attention of those who can heal — heal by virtue of treating illness as well as conditions.

With crime and violence in our streets, assassination of our leaders, rejection of law and order, abuse of drugs and other maladies, we must turn to those who can heal and seek their help. Is not the pharmacist one who can be turned to? Is he not often the one looked up to in his community?

IT WOULD SEEM THAT the pharmacist, as a respected member of his community, could — if he would — influence in some way the conditions that exist surrounding his place of practice.

If he would become more involved with the youth of his area, trying to understand their problems and reasons for unrest, he might be able to help them find their rightful place in society.

In addition to treating the physical ills of mankind, we must also treat the social ills, for often one is dependent on the other.

Couldn't the pharmacist organize a group in his community that could direct their attention to improving the community, assisting those who need help both physically and materially?

Just in the health area, pharmacists could perform valuable services helping to educate the young about drug abuse, venereal disease, alcoholism, malnutrition and the ways to overcome these problems.

Greater emphasis must be directed toward preventive medicine — and here, certainly, the pharmacist can play an important role.

All too often, pharmacists' only concern about OEO centers and other government sponsored programs is with the prescriptions or possible loss thereof. There is, however, more to consider than the mere dispensation of the prescription. Unless we consider these other responsibilities, there may be little opportunity to ensure the use of private practice in rendering pharmaceutical care.

WE HAVE TALKED ABOUT the pharmacy being a health information center — but we must do more than that. Those who most require health information are not likely the ones to seek it — instead, they must be sought out. The pharmacist cannot do this unless he leaves the comfort of his prescription department and goes out into the streets to examine the conditions and find those who need care. He must then see that they receive proper medical attention.

These are the things we are talking about when we speak of comprehensive health care. If we reject government providing such care through OEO centers, etc., then we, as responsible citizens and health professionals, must substitute in its place our own time and interest.

Perhaps if we treat the physical ills of our society, the social ills will become lessened.

PHARMACISTS OF THE FUTURE

This leads us to a consideration of the future role of the pharmacist. For anyone who thinks we can preserve the status quo — I am afraid he, like Rip Van Winkle, has been asleep for all too many years.

Society is changing — and changing rapidly. Unless we change along with it, we will be left so far behind that our contemporaries will soon forget who we were.

Some pharmacists reject the theories proposed by Dr. Goddard and others who maintain that the pharmacy of tomorrow will be somewhat different from today.

It is an exciting experience to live through a revolution, but it is a regretful experience to live through one and not know it is taking place.

I am afraid all too many pharmacists are suffering through a regretful experience. They do not see the changes that are taking place — because it is easier not to.

As long as there are prescriptions to be dispensed and money is coming in, it is easier to not concern ourselves with how much longer this will last.

THERE ARE THOSE, however, who do recognize that the pharmacist of the future, because of the pressures of society and the ever-changing world, will be practicing his profession within the next two or three decades in a different manner than he is today. At this time, I am participating, along with eleven others from across the nation, in a study designed to determine the future "pharmacist." This research project will consider his educational experience, his environment, and his professional responsibilities.

I am not certain of what the pharmacist of the future will be, but I do know he will resemble something different from what he is today.

There have been enough significant changes in the delivery of pharmacy care in this past decade to convince me that this is only the beginning. We are only on the threshold of finding what our future role will be and how it will be performed.

THINK ALONG WITH ME, if you will,
— about the impact that prefabricated medicine has had on our profession —

— about the changes in our educational requirements —

— about the involvement of government in our profession —

— about the degree of specialization and sophistication in medical care.

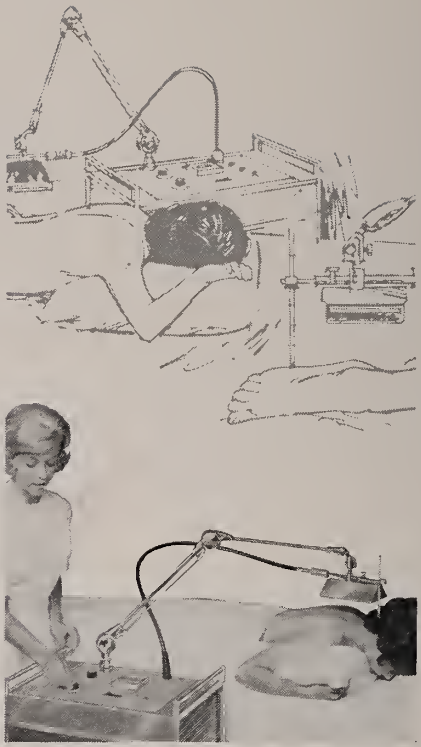
In how short a span has this occurred? Then tell me if we are not witnessing a resolution in the concepts and delivery of health care.

Can you envision the future? I can't entirely, but I have some ideas. I would be interested in your thoughts. If we can think about the change that is occurring and plan for it, it might be more palatable and easier to accept.

Again, we need to recognize that as individuals, survival will be difficult. But as one aggregate working through a strong, progressive professional association, we can not only survive but become strengthened and perhaps even more useful to our society.

So long as I have the privilege of serving you, I will work toward this end.

With your support and the support that you can engender from others, I am confident we will have a bright future.



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MSMS members, when they are in Chicago, are cordially invited to visit the AMA Headquarters at 535 N. Dearborn.

Last year, nearly 900 persons toured the AMA building. The AMA extends a warm welcome to all physicians, their wives and guests to take a 40-minute tour to become better acquainted with the AMA's organizational structure, its major areas of activity and some of the numerous services available to physicians, as well as the public. Tours are given between 9:00 a.m. and 4:00 p.m., Monday through Friday.

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National Report Suggests Ways "to Save the Cities"

What future do the cities in Michigan and the nation face?

Every MSMS member is concerned with this question and many physicians are working actively on city councils, school boards, zoning agencies, planning commissions and other official bodies to help seek solutions.

The Report of the National Advisory Commission on Civil Disorders evaluates problems and possible courses of action. Following are some direct quotations to help MSMS better understand changing conditions and the recommended steps toward solutions.

THE REPORT CONTENDS that "the only possible choice for America to save the cities is to pursue integration by combining ghetto enrichment with policies which will encourage Negro movement out of central city areas."

"By 1985, the Negro population in central cities is expected to increase by 72 percent to approximately 20.8 million. Coupled with the continued exodus of white families to the suburbs, this growth will produce majority Negro populations in many of the nation's largest cities.

"The future of these cities, and of their burgeoning Negro populations, is grim. Most new employment opportunities are being created in suburbs and outlying areas. This trend will continue unless important changes in public policy are made.

"In prospect, therefore, is further deterioration of already inadequate municipal tax bases in the face of increasing demands for public services, and continuing unemployment and poverty among the urban Negro population.

"Development of a racially integrated society, extraordinarily difficult today, will be virtually impossible when the present black ghetto population of 12.5 million has grown to almost 21 million.

"To continue present policies is to make permanent the division of our country into two societies; one, largely Negro and poor, located in the central

(Continued on 1534)

Many Conditions Involving Negroes "In State of Crisis" Says Report

"Many facts and statistics about the Negroes are contained in the Report of the National Advisory Commission on Civil Disorders, and some of them are repeated below:

"Throughout the 20th Century the Negro population of the United States has been moving steadily from rural areas to urban and from South to North and West. In 1910, 91 percent of the nation's 9.8 million Negroes lived in the South and only 27 percent of American Negroes lived in cities of 2,500 persons or more. Between 1910 and 1966 the total Negro population more than doubled, reaching 21.5 million, and the number living in metropolitan areas rose more than five-fold (from 2.6 million to 14.8 million). The number outside the South rose eleven fold (from 880,000 to 9.7 million).

"Although there have been gains in Negro income nationally, and a decline in the number of Negroes below the "poverty level," the condition of Negroes in the central city remains in a state of crisis. Between 2 and 2.5 million Negroes — 16 to 20 percent of the total Negro population of all central cities — live in squalor and deprivation in ghetto neighborhoods.

"Negro men are more than three times as likely as white men to be in low paying, unskilled or service jobs. This concentration of male Negro

(Continued on 1534)

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an underlying depression.

---

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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

CONTINUED: NATIONAL REPORT SUGGESTS WAYS "TO SAVE THE CITIES"

cities; the other, predominantly white and affluent, located in the suburbs and in outlying areas.

"Equality cannot be achieved under conditions of nearly complete separation. In a country where the economy, and particularly the resources of employment, are predominantly white, a policy of separation can only relegate Negroes to a permanently inferior economic status.

"Enrichment must be an important adjunct to integration, for no matter how ambitious or energetic the program, few Negroes now living in central cities can be quickly integrated. In the meantime, large-scale improvement in the quality of ghetto life is essential.

"But this can be no more than an interim strategy. Programs must be developed which will permit substantial Negro movement out of the ghettos. The primary goal must be a single society, in which every citizen will be free to live and work according to his capabilities and desires, not his color.

"The National Advisory Commission on Civil Disorders Report offers many recommendations, including the following three 'toward the reaction of a true union:'

> "Opening up opportunities to those who are restricted by racial segregation and discrimination, and eliminating all barriers to their choice of jobs, education and housing.
>
> "Removing the frustration of powerlessness among the disadvantaged by providing the means for them to deal with problems that affect their own lives and by increasing the capacity of our public and private institutions to respond to these problems.
>
> "Increasing communication across racial lines to destroy stereo-types, to halt polarization, end distrust and hostility, and create common ground for efforts toward public order and social justice."

Continued: Many Conditions Involving Negroes "In State Of Crisis" Says Report

employment at the lowest end of the occupational scale is the single most important cause of poverty among Negroes.

"In 1966, about 11.9 percent of the nation's whites and 40.6 percent of its non-whites were below the "poverty level" defined by the Social Security Administration (currently $3,335 per year for an urban family of four). Over 40 percent of the non-whites below the poverty level live in the central cities.

"The infant mortality rate for non-white babies under the age of one month is 58 percent higher than for whites; for one to 12 months it is almost three times as high.

"The 500,000 "hard-core" unemployed in the central cities who lack a basic education and are unable to hold a steady job are made up in large part of Negro males between the ages of 18 and 25. In the riot cities which we surveyed, Negroes were three times as likely as whites to hold unskilled jobs, which are often part time, seasonal, low-paying and "dead-end."

"Many ghetto residents simply cannot pay the rent necessary to support decent housing. In Detroit, for example, over 40 percent of the nonwhite occupied units in 1960 required rent of over 35 percent of the tenants' income."

COMING AMA CONVENTIONS

1968: Miami Beach (Dec 1-4)
1969: New York City (July 13-17)
Denver (Nov 30-Dec 3)
1970: Chicago (June 21-25)
Boston (Nov 29-Dec 2)
1971: Atlantic City (June 20-24)
New Orleans (Nov 28-Dec 1)
1972: San Francisco (June 18-22)
Atlanta (Nov 26-29)
1973: New York City (July 15-19)
Anaheim (Nov 25-28)
1974: Chicago (June 16-20)
Portland, Ore (Dec 1-4)

IN MEMORIAM

M. A. Baeff, M.D., Detroit

Michael A. Baeff, M.D., retired Detroit physician, died October 13 at the age of 85.

Born in Russia, Doctor Baeff received his medical degree from the Moscow University Medical School in 1911. From 1911 to 1923 he served in the medical military service of the Russian army.

He moved to Detroit in 1923 and joined the staff of the Rouge Hospital at the Ford Motor Company plant in Dearborn, where he was employed until his retirement in 1949.

Doctor Baeff was the founder of the Russian-American Club of Detroit.

D. J. Carothers, Jr., M.D., Charlotte

Daniel J. Carothers, Jr., M.D., Charlotte physician and surgeon, died October 25. He was 57.

Doctor Carothers had practiced in Charlotte for 22 years and was a past president of the Eaton County Medical Society.

He was graduated from Ohio Wesleyan University in 1934 and from the Western Reserve University Medical School in 1938. His internship was at Cleveland City Hospital, 1938-39. He did a residency in obstetrics and gynecology at Cleveland City Hospital, 1939-40, and was chief resident in surgery at Lutheran Hospital, Cleveland, Ohio, from 1946-47.

A flight surgeon in World War II, he received the Bronze Star for service in the South Pacific.

Doctor Carothers was a Fellow of the American College of Surgeons and a member of Alpha Kappa Kappa.

S. G. Delbert, M.D., Kalamazoo

Stewart G. Delbert, M.D., Kalamazoo general practitioner, died November 11, at the age of 59.

Doctor Delbert received the M.D. degree from the Wayne State University School of Medicine in 1941. His pre-medical education was at Michigan State University and Wayne State University.

From 1941-45 he was a member of the Army Medical Corps. Following the war, he served continuously in the Army Reserves and was a member of the Reserve Officers Association and the American Legion.

He was affiliated with Borgess Hospital and Bronson Methodist Hospital in Kalamazoo.

R. J. DeMol, M.D., Grand Rapids

Richard J. DeMol, M.D., Grand Rapids, the Michigan Hemophilia Foundation's Doctor of the Year in 1966, died November 12. He was 65.

Doctor DeMol was honored by the Michigan Chapter of the National Hemophilia Foundation when he was selected Doctor of the Year for his dedicated care of a hemophilic patient. The award was presented to Doctor DeMol during the MSMS Annual Session in Grand Rapids in 1966.

He held an A.B. degree from Calvin College in Grand Rapids and received the M.D. degree from the Northwestern Medical School, Illinois, in 1930. He was affiliated with Blodgett Hospital in Grand Rapids and was on the courtesy staff of Butterworth and St. Mary's Hospitals.

Doctor DeMol was a member of the Academy of General Practice and the Chamber of Commerce.

L. C. Dickson, M.D., Detroit

Laurie C. Dickson, M.D., Detroit internist, died October 6 at the age of 47.

Doctor Dickson was graduated in 1943 from the Johns Hopkins University School of Medicine, Baltimore, Maryland. He served as a captain in the Army Medical Corps from 1946-48.

He was a member of staff at Henry Ford Hospital, Detroit, since 1950.

Doctor Dickson was a member of the American Society of Internal Medicine and an associate of the American College of Surgeons. His medical fraternity was Phi Chi.

Survivors include his wife, Mary D. Dickson, M.D., who is a practicing physician.

S. L. Loupee, M.D., Dowagiac

A news article about the death of Doctor Loupee appears in this issue on Page 1484.

R. A. McGarry, M.D., Flint

Roy A. McGarry, M.D., long-time Flint general practitioner, died October 1. He was 80.

Doctor McGarry had practiced in Flint since 1919.

He received the M.D. degree from the University of Michigan Medical School in 1912, and then served as an instructor there for five years. During World War I he was a captain in the Medical Corps.

Doctor McGarry was a Life Member of MSMS, a Fellow of the Academy of International Medicine and a member of the Elks.

J. T. Sample, M.D., Saginaw

John T. Sample, M.D., Saginaw physician for over 50 years, died October 4. He was 85.

Doctor Sample was graduated in 1908 from the University of Michigan Medical School. After a year as a resident at University Hospital, he spent a three-year residency at Johns Hopkins Hospital. From 1912-14 he studied neuropsychiatry and general medicine in Munich and Vienna. He was a member of the U.S. Army Medical Corps from 1916-19, serving part of that time as division psychiatrist.

A Life Member of MSMS, Doctor Sample was a Fellow of the American Psychiatric Association and of the American College of Physicians, and a member of Alpha Omega Alpha, Nu Sigma Nu, and Sigma Xi. He was a member of staff at all three Saginaw medical hospitals.

Doctor Sample was a Past President of the Saginaw County Medical Society, Saginaw Rotary Club and Saginaw Valley Torch Club.

N. M. Ward, M.D., Flint

Nell M. Ward, M.D., Flint physician for 48 years, died November 4. She was 79.

Doctor Ward, born in 1889, was graduated in 1915 from the Woman's Medical College in Pittsburgh, Pennsylvania.

She maintained a general practice with special attention to obstetrics and gynecology. Her hospital affiliations were with McClaren General Hospital and St. Joseph Hospital in Flint.

A Life Member of MSMS, she retired from active practice in 1966.

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* 1904 - 1967

Michigan Health Council Observes Silver Anniversary of Service

It was 25 years ago that the Michigan Health Council was founded by the "Big Four in Health Care" — the Michigan State Medical Society, the Michigan Hospital Association, Michigan Hospital Service and Michigan Medical Service.

The officers of these organizations recognized the desirability of comprehensive planning and organized the Council to bring complete health services to all of the people in Michigan through private means and voluntary methods by:

1. Coordinating the efforts of the four founding organizations and other groups interested in the health of the people;

2. Conducting a general education program regarding the advantage to the health of the people to be gained through the private practice of medicine and dentistry, and the operation of voluntary, non-profit hospitals;

3. Taking all necessary and practical steps to arrange for the availability of medical, dental, hospital, and related services.

THE FOUR ORGANIZATIONS did considerable joint comprehensive health planning during the first years of the Michigan Health Council. One of the first was planning a Survey of Michigan Hospitals to determine the scope of hospital services and the availability and distribution of doctors, nurses, and other health manpower throughout the State.

Another important joint effort was a Comprehensive Public Opinion Survey to determine the type of hospital-medical-surgical services that Michigan residents and their employers desired and were willing to pay for under a prepayment program. At the time, only nine percent of Michigan's citizens were covered. As a direct result of the Public Opinion Survey, the most comprehensive prepayment program ever offered was provided Michigan residents; and, within a year, there were more than 1,250,000 subscribers, and the plan became the model for the United States.

About this time, World War II ended and hundreds of thousands of veterans and doctors began returning to Michigan. The Council developed a comprehensive plan to organize community health councils in all areas of Michigan to utilize the professional skills of the returning doctors by building community hospitals and rural medical centers in areas where there was a need. Efforts to organize the community health councils were fruitful, and the prime functions of the new local councils were to:

a. aid in the promotion of better and more adequate health facilities for the community;

b. assist in the development of health information centers;

c. assist in the general development of the health professions and their objectives through coordination, surveys, health education programs, etc.

Upwards of 70 local health councils continue to function today. Some are small and have only one or two major activities, while others are in metropolitan communities with broad membership and projects.

Recognizing the need for involving many more organizations with an interest in health in the Michigan Health Council, the membership of the Council was expanded substantially in 1948 to include the American Cancer Society, the Michigan Tuberculosis Association, the Michigan Heart Association, the Michigan State Nurses Association, the Michigan Farm Bureau, and many other voluntary health agencies as well as the Michigan Department of Health.

Among the efforts of the expanded program were the sponsorship of the Michigan Rural Health Conference and the development of a film showing how community health councils could be effective in rural areas in developing rural medical centers, community hospitals, etc. The Conference gave Michigan farm leaders and farm families an opportunity to sit down with doctors and other health professions to plan new health programs and health care facilities to improve the health of rural families.

Another 15-minute film was produced in cooperation with the Michigan State Medical Society to promote careers in health. A brochure, "Planning Your Career as a Medical Associate," was produced as a companion to the film and has been distributed throughout Michigan. It was the first health career publication of its kind, covering numerous health occupations, and was reprinted by several other states.

In the early 1950s the Brookings Institute selected Michigan as a pilot state in its National

1943

Survey of Health Resources, and the Council's officers, staff and member organizations played a major role in the planning and conducting of this important study. The Council collaborated with the American Medical Association in planning the First National Conference on "M.D. Participation in Health Councils," held in Detroit in October 1950.

In 1951, with special support from the Michigan State Medical Society and the Michigan Heart Association, planning was begun for a state-wide educational program on the importance of "Periodic Health Appraisal Examinations." A new publication, the "MHC Bulletin," was developed to keep Michigan citizens advised on the health news and events of interest to lay and professional people.

The Council embarked on the first health educational television series over WJBK-TV, Channel 2, Detroit. This continued for more than 12 years as the "Court of Health" and later as "Decision" with the Michigan Association of the Professions as co-sponsor.

Similar television series were arranged for Grand Rapids and Cadillac and still are being conducted there. The Council also has received a considerable amount of television time down through the years from other television stations throughout Michigan, particularly from Channel 6, Lansing, on the "Formula" program, sponsored by the Michigan Association of the Professions.

In December 1952 the Michigan State Medical Society invited the Council to establish an M.D. Placement Service. A comprehensive state-wide survey was conducted to determine the need for physicians. With major financial assistance from The Upjohn Company, the Council has developed a program that, for many years, has been considered the most outstanding in the Nation. More than 800 medical doctors have used the program in finding a Michigan community in which to practice. Currently the Council is assisting 126 communities that are in need of family physicians and more than 50 communities that are looking for medical specialists for their communities, their hospitals, public health agencies, industrial medical departments, mental hospitals, student health services, etc.

Recognizing that Michigan offered numerous services from voluntary as well as official health agencies of which the public was not aware, the Council planned a Directory of Michigan Health Organizations. This has proved to be a most useful publication and is published every three years. A recent feature of the Directory is the listing of health, safety and health career films.

In 1954, in cooperation with the National Health Council and the Michigan Department of Health, the Council developed a comprehensive plan for promoting public health units in unorganized areas. A "Citizens Conference on Public Health" was held at the University of Michigan on March 3-4-5, 1954.

In 1957 the Michigan Health Council again substantially increased its membership to 90 organizations and activities. The W. K. Kellogg Foundation approved a plan to develop a Dentist Placement Service, and The Upjohn Company agreed to sponsor the Veterinary Placement Service in addition to the M.D. Placement Program; and the Health Careers Program was greatly expanded.

The Council also served to plan and coordinate another important health program since 1965 — the Michigan Council on Smoking and Health. Sixteen state-wide voluntary and official organizations with a prime interest in eliminating cigarette smoking contribute financially or with staff to the Council. The National Clearinghouse on Smoking and Health has assisted the MCSH during the past two years with a special demonstration grant.

During the past five years, the Council has helped MSMS plan and coordinate Community Health Week.

The Health Council has also had a long-time interest in the elderly. More than 400 senior citizens attended the quackery conference held at Sault Ste. Marie during our 1st Annual Upper Michigan Health Conference in 1965. Quackery also was a feature of our 2nd Upper Michigan Health Congress at Marquette and our 3rd Annual Upper Michigan Health Congress held at Houghton during Michigan Week in 1968.

During the Silver Anniversary Year, the Council's health manpower efforts have been expanded to include the Health Careers Mobile. The Health Careers Mobile, started by MSMS, has been financed entirely through cooperative effort on the part of many voluntary organizations and foundations such as the Michigan State Medical Society, the Sears-Roebuck Foundation, the Michigan

Foundation for Medical and Health Education, Gerber Baby Foods Fund, and the Marlette Homes, Inc.

Through the years there has been a great amount of voluntary health planning going on in Michigan through the Council and its membership. This membership now includes nearly every Michigan United Fund health organization as well as nearly every other voluntary or governmental agency, professional association, college and university, foundation and industry with a major interest in health. This coordination has not required a huge expenditure of private or tax funds, as the planning and programming of the Council have been accomplished with annual budgets ranging from $20,000 to $85,000. Nearly all of the funds have come from grants from member organizations with a minimum from public agencies. Thousands of professional and lay citizens throughout Michigan have donated time to the Council annually.

The past is prologue, and the successes which have been made can best serve as a springboard to keeping Michigan outstanding in planning and providing health services to its present and future citizens.

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STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published Semi-monthly, Tri-monthly in November and December, 26 issues, mailed at Lansing, Michigan in Ingham County for December 1, 1968.

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2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
3. The Publisher is the Michigan State Medical Society. The Scientific Editor is John W. Moses, M.D., 1713 Sunset Blvd., Royal Oak, Michigan 48067; The Managing Editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.
4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
5. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.
6. A. The total number of copies printed averages 7,950 per issue with a single issue nearest to filing date accounting for 7,926 copies.

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   C. Sales to dealers, number none.

   D. Free distribution by mail carrier or other means: 986.

   E. Total number of copies distributed is 7,891.

I certify that the statements made by me above are correct and complete.

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Michigan State Medical Society

MSMS Members In The News

BY CAROL MAXWELL
OF THE MSMS STAFF

Dean Carron, M.D., Ann Arbor, has been appointed by Governor Romney to the State Board of Marriage Counselors for a term ending in June, 1970. Doctor Carron, a psychiatrist, is national director of the Family Service Association of America.

Edmond L. Cooper, M.D., Royal Oak, was a visiting professor of ophthalmology for two days at the University of British Columbia in Vancouver and for a day at the University of Alberta in Edmonton. He also recently addressed the semi-annual meeting of the Arizona Ophthalmological Society on "The A and V pattern: Diagnosis and Treatment" and "The Surgery of Congenital Nystagmus."

Three Battle Creek physicians received certificates of appreciation for 25 years of public service from the National Selective Service. Honored were Roy H. Baribeau, M.D., and Lloyd E. Verity, M.D. The award to Edwin L. Hansen, M.D., was presented posthumously.

Homer Stryker, M.D., Kalamazoo, was the recipient of a presidential citation from the President's Commission on Employment of the Handicapped. The award was presented to Doctor Stryker, orthopedic surgeon and inventor of several orthopedic instruments, at an "Ability Counts Banquet" in Lansing.

Alfred Swanson, M.D., Grand Rapids, was featured in a special documentary television program showing Doctor Swanson at work helping to establish a volunteer medical program to treat Vietnamese civilians. A WOOD-TV photographer accompanied Dr. Swanson on his recent trip to Vietnam — his fifth in the past eight years.

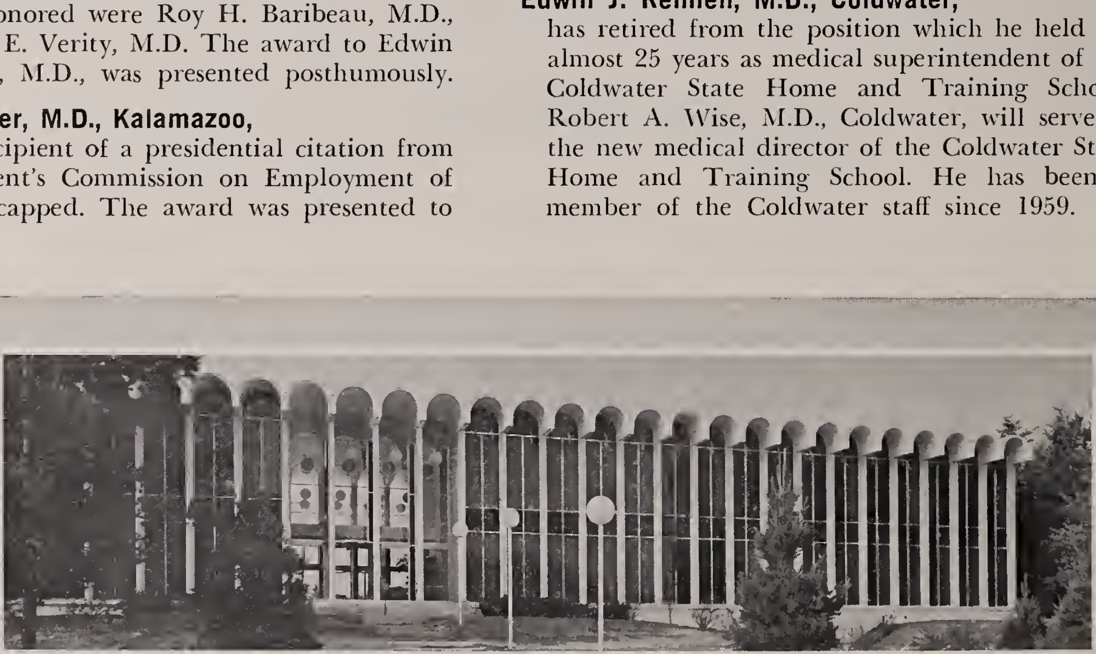
M. S. Brent, M.D., Detroit, has retired from the private practice of medicine to devote more time to the administration of the Brent General Hospital, which he founded more than 25 years ago.

Joseph Scher, M.D., Mt. Clemens, reigned as "King of Football" at the Mt. Clemens Alumni Night football game. That title, an annual tribute to an outstanding man of the community, went this year to Dr. Scher for his devoted service as school and team physician for 33 years.

Douglass Haddock, Jr., M.D., Portage, is the author of an article in the October 28 issue of *Medical Economics* describing a method to set proper charges on the basis of your costs."

Samuel Gershon, M.D., New York City, former U-M Medical School faculty member, has been promoted to professor of psychiatry at New York University School of Medicine, where he is director of the Neuropsychopharmacology Research Unit. He was chief of the schizophrenia and psychopharmacology project at the University of Michigan from 1959-61.

Edwin J. Rennell, M.D., Coldwater, has retired from the position which he held for almost 25 years as medical superintendent of the Coldwater State Home and Training School. Robert A. Wise, M.D., Coldwater, will serve as the new medical director of the Coldwater State Home and Training School. He has been a member of the Coldwater staff since 1959.



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MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY VOLUME 67, NUMBER 26 DECEMBER 1968

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Digest of Proceedings
1968 MSMS House of Delegates

1968 House of Delegates Proceedings
103rd Annual Session
Michigan State Medical Society

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Michigan State Medical Society
103rd Annual Session
September 22-24, 1968

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The House of Delegates of the Michigan State Medical Society, meeting at the Sheraton-Cadillac Hotel, Detroit, Michigan, on September 22, 23, and 24, 1968, convened at 8:20 p.m. on Sunday, September 22, James B. Blodgett, MD, Speaker, and Vernon V. Bass, MD, Vice-Speaker, presiding.

2. Invocation

The Speaker called upon R. R. Cooper, MD, to give the invocation.

3. Report of Credentials Committee

Chairman K. T. McGunegle, MD, reported, "There are 132 Delegates seated, the majority of whom are not from any one county."

4. Report of Committee on Rules and Order of Business

Chairman H. A. Scovill, MD, recommended adoption of the printed order of business, particularly Item No. 21 thereof which specified that resolutions may *not* be introduced after the close of the second meeting, tomorrow morning, September 23, unless by consent of two-thirds of the seated delegates.

This procedural change, recommended by the House Committee on Procedures and subsequently discussed at Councilor District Conferences, was to expedite the business of the House while still providing full opportunity for the introduction of matters which must be deliberated.

The Committee also recommended that the House give the Speaker the right to recess its proceedings to a time certain at his discretion and without a vote of the body.

Finally, it was recommended that Robert's Rules of Order govern the proceedings of the House, except for recess power.

The report was adopted.

5. Speaker's Remarks — J. B. Blodgett, MD

This is the first annual session of the House at which it is my privilege to preside. The honor of this office is derived from the high character and devotion of those delegates to this House who have represented their colleagues over the years, and from the excellence and fairness of the Speakers who have served this House in the past.

It is the Speaker's duty to conduct the affairs of a deliberative assembly in such a way that the business may be effective, expeditious, systematic, uniform and equitable. The purpose is to implement the rule of the majority and at the same time protect the rights of the minority.

The House and the Speaker are indebted to Dr. Noyes Avery's Committee on Procedures of the House. His recommendations for more efficient conduct of our business have been incorporated into this meeting and are recorded in this report.

One of these innovations is the Tuesday dinner meeting of the House. At that time it will be our privilege to install the new President and to honor our specially distinguished members. I have asked Mr. Stewart Kerr, our Legal Counsel, to act as our parliamentarian. I wish to express my thanks to the staff for their tremendous assistance in preparing for this meeting.

(The following report of the Speaker was presented to the Delegates in printed form.)

This is a brief review of the implementation of resolutions adopted by the 1967 House of Delegates. (For complete text of resolutions with House action, refer to the Digest of Proceedings — Part 2, *Michigan Medicine*, December, 1967.)

Summary.

A. Resolutions adopted:
   1. Commendation or approval: Resolutions 37, 48, 53, 61, 62, 63, 64
   2. Economics: Resolutions 14, 20, 32, 33, 36, 41, 44, 59
   3. Bylaws: Resolutions 7, 8, 39, 55
   4. Legislative: Resolutions 3, 13, 40, 42, 49, 51, 58
   5. Miscellaneous: Resolutions 6, 10, 17, 18, 21, 22, 23, 24, 25, 31, 35, 46, 47, 52, 54, 56, 57, 60

B. Resolutions disapproved: Resolutions 1, 4, 5, 9, 11, 29, 30, 34 (but House appointed Committee to Study Duties of the President), 38, 45

C. No action: Resolutions 2, 12, 15, 16, 19, 26, 27, 28, 43, 50

Res. 1 — Section Delegates, Right to Vote. This resolution was disapproved by the House.

Res. 2 — Hospital Privileges. The House took no action on this resolution.

Res. 3 — Repeal of Basic Science. Although a concerted attempt was made, SB 227 (repeal of Basic Science), which had passed the State Senate in 1967, failed to pass the House of Representatives in 1968, largely because of the refusal of the House State Affairs Committee to permit the House to debate and vote upon the bill. (The 1968 Legislature did adopt a bill, supported by MSMS, which makes possible the waiving of the Basic Science examination for any licensure candidate who has previously passed "substantially equivalent" examinations as given by the National Board of Medical Examiners. This law takes effect 90 days following adjournment of the 1968 session.)

Res. 4 — Definition of Specialist. This resolution was disapproved by the House.

Res. 5 — Rescind Resolution 22, 1966 MSMS House of Delegates. This resolution was disapproved by the House.

Res. 6 — William Beaumont Commemorative Postage Stamp. MSMS prepared a resolution which was adopted by the Michigan Legislature, which will give impetus to MSMS plans, as directed by this resolution, to petition the Postmaster General of the United States to issue a commemorative stamp honoring Doctor Beaumont on the 150th anniversary (1822-1972) of the "Mackinac Island Miracle." MSMS is coordinating its efforts with the State Medical Society of Wisconsin.

Res. 7 — Number of Terms for MSMS Councilors. This change in the Bylaws, limiting to three the consecutive terms Councilors may serve, was incorporated in the 1967 revision of the MSMS Constitution and Bylaws.

Res. 8 — Physical Medicine. This change in the Bylaws, establishing a Section on Physical Medicine, was incorporated in the 1967 revision of the MSMS Constitution and Bylaws.

Res. 9 — Medical Advisors to Michigan Partners of the Alliance. This resolution was disapproved by the House.

Res. 10 — Board of Pharmacy Rules & Regulations 338.486-16(c). This resolution, requesting that a Board of Pharmacy rule be rescinded, was referred to the MSMS Liaison Committee with the Michigan State Pharmaceutical Association for further study and report back to the House. The Committee is continuing its study of this problem and will make recommendations to the House in 1969. (See Annual Report of Committee.)

Res. 11 — Guidelines on Utilization. This resolution was disapproved by the House.

Res. 12 — Hospital Utilization Review Manual. The House took no action on this resolution.

Res. 13 — Single Medical Practice Act. A proposed bill to establish a single medical practice act is being developed by a subcommittee of the Legal Affairs Committee and will be submitted to the House of Delegates in 1968 for its consideration.

Res. 14 — Joint Committee with State Bar of Michigan to Study the Problem of Malpractice Suits. This resolution, concerning the feasibility of establishing a commission to study the problem of increasing malpractice suits against physicians, has been favorably considered by both the MSMS and State Bar committees. Representatives from both professions soon will be appointed so that this important study can be underway.

Res. 15 — Utilization Control. The House took no action on this resolution.

Res. 16 — Utilization Control. The House took no action on this resolution.

Res. 17 — Financial Remuneration for MSMS Officers. This resolution directed the Finance Committee of The Council to investigate the concept of adequate financial remuneration for MSMS officers, and suitable means of securing funds for this purpose, and report to the 1968 House of Delegates.

The Finance Committee has studied this matter during the past year and surveyed past officers of MSMS. The Committee finally concluded that there was no general agreement on the question of remuneration as to method, amount, desirability, or who should be remunerated. (See Annual Report of The Council for further detail.)

Res. 18 — Health Information Research Institute. This resolution directed The Council to provide for organizational expenses of the Health Information Research Institute incidental to its incorporation, materials necessary to present the principles of the Institute to prospective sponsors, and such seed money as The Council deems necessary and available within the limits of its present budget.

This item was considered by the Finance Committee and The Council and incorporated in the 1968 MSMS budget.

Res. 19 — Hospital Utilization Review Manual. The House took no action on this resolution.

Res. 20 — Physician Responsibility for Physical and Occupational Therapies. This resolution, which related to procedures of the carrier and fiscal agent for the Medicare program, was forwarded to Michigan Medical Service for study and implementation.

Res. 21 — Chiropractic. This resolution "encouraged MSMS to initiate an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult." Educational conferences on health quackery were held in Detroit and Lansing for the public and physicians. Recommendations for a new ongoing "MSMS Committee on Health Quackery" to carry out an educational effort grew out of the Lansing invitational conference April 1 and were adopted by The Council in June. This committee now will seek continually to educate the public about quackery, including the cult of chiropractic.

Res. 22 — Study of Adequacy of Training of Certain Para-Medical Personnel. This resolution directed the Committee on Rehabilitation, with the Education Liaison Committee, to study the adequacy of training, the practice procedures allowed, and the limitations of responsibilities of physical therapy assistants, and report to The Council. Preliminary discussions were held with the three medical schools on this question. However, the Committee on Rehabilitation did not feel it could make the study as outlined in the resolution, but felt that it was in a good position to review such programs which come into existence in the state. The Committee has been aware of such programs in Michigan, through some of its committee members, and felt that the existing programs had adequate curricula. The Committee will review any new programs for teaching and training paramedical personnel in the state and will keep The Council informed.

Res. 23 — Recognition of the Board of Registration of Physical Therapists. This resolution instructed the MSMS Rehabilitation Committee to inform MSMS members re "qualifications of the different groups of practicing physical therapists." After considering this resolution, the Rehabilitation Committee informed The Council that "there is only one body of registered physical therapists, with no other level of physical therapists being recognized at this time. The Michigan law definitely sets forth the qualifications of a physical therapist. An explanatory letter and a copy of the Michigan law was sent to component society secretaries."

Res. 24 — AMA Delegation Chairman to Attend Council Meetings. This resolution directed that the current AMA Delegation Chairman be invited to attend all meetings of The Council and this is routinely done.

Res. 25 — Care of Handicapped Children. The House took no action on this resolution re MSMS support of the Michigan Ad Hoc Committee for the Care of the Handicapped Child, but did approve its intent. The reference committee noted "that this effort is in accord with the reference committee's recommendation that a new special committee of MSMS be formed for coordinating the care of the handicapped children." The reference committee recommended, therefore, that the Ad Hoc Committee of the American Academy of Orthopedic Surgeons channel its efforts through the MSMS.

After considering this resolution and the referenece committee action, the MSMS Committee on Rehabilitation adopted a motion that the Committee cooperate in all ways possible with the Committee for the Care of the Handicapped Child of the American Academy of Orthopedic Surgeons and maintain liaison with the other organizations, agencies and departments involved in the care of handicapped children.

Res. 26 and Res. 27 were withdrawn by the introducers.

Res. 28 — Physician Involvement in Operation of Variable Fee Program. The House took no action on this resolution.

Res. 29 — Blue Shield Responsibility to House of Delegates. This resolution was disapproved by the House.

Res. 30 — Michigan Medical Service. This resolution was disapproved by the House.

Res. 31 — Supporting Appropriations for Four-Year Medical School at MSU. This resolution directed MSMS to support the request of the State Board of Education for an appropriation to enable MSU to expand its College of Human Medicine to a four-year medical school.

Letters indicating MSMS support of this request were sent to the Governor and other appropriate state officials, and subsequently the requested funds were appropriated by the Legislature.

Res. 32 — Participation in Michigan Medical Service. This resolution recommended to the Board of Michigan Medical Service that individual case participation be allowed in all new contracts.

The resolution was transmitted by letter to Michigan Medical Service for information and implementation. Subsequently MSMS reported to The Council that a study was being undertaken to determine the effect of per case participation on the overall participation program.

Res. 33 — Blue Shield "Action Line" for Medicare-Medicaid Cases. This resolution recommended to the Michigan Medical Service Board that it "establish a better mechanism than is now present to resolve promptly questions from doctors concerning Medicare and Medicaid cases."

This resolution was transmitted to MMS by letter for information and implementation. Subsequently Blue Shield reported to The Council that in the fall of 1967 a special handling section was established for processing status inquiries. The staff of the Personal Services Department was increased, and the number of Professional Relations and Telephone Service representatives was increased. A new modern Telephone Service area has been constructed in the headquarters office to speed internal handling of physicians' calls. In addition, a member of the Blue Shield public relations staff is coordinating the handling of especially urgent or sensitive inquiries and expediting their processing in cooperation with other Blue Shield departments.

Res. 34 — Responsibilities of MSMS President. This resolution was disapproved by the House. However, the House approved a reference committee recommendation that an ad hoc committee of the House of Delegates be appointed to re-evaluate the executive duties of the President. This committee is studying the matter and will report directly to the House.

Res. 35 — Approval of Screening Programs. The resolution directed that The Council limit its approval of screening programs to those previously approved by the component medical society or societies in which the program is to be carried out.

This MSMS policy was in effect prior to the time the resolution was adopted, so no further action was required.

Res. 36 — Proposed Blue Shield Benefits for Sterilization. The resolution directed that MSMS through appropriate officers apprise Michigan Medical Service of the Society's opposition to the MMS restriction denying surgical benefits for sterilization procedures, and request that the restriction be eliminated.

This matter was brought to the attention of the Blue Shield Board by MMS officers and Blue Shield has advised MSMS that the Blue Shield Medical Advisory Committee has approved the inclusion of inpatient male and female sterilization for medical necessity as a benefit under the M-75 program. It already is included in the new MVF programs.

Res. 37 — Honoring Physicians Who Have Served in Viet Nam. This resolution commended several Michigan physicians who had served in Viet Nam.

The March issue of *Michigan Medicine* was dedicated to MSMS members who have served in Viet Nam during the past year, with articles and photographs by and about the physicians. (AMA plaques honoring physicians who have served in Viet Nam since the 1967 House of Delegates will be presented at the 1968 House of Delegates meeting.)

Res. 38 — New Blue Shield Program, Deletion of Certain Benefits. This resolution was disapproved by the House.

Res. 39 — Medical Society Membership for Osteopathic Physicians. This resolution directed that component medical societies be encouraged to offer associate memberships to osteopaths on an individual basis, and outlined provisions whereby such associate members of component societies could be admitted to associate membership in MSMS.

Component society officers were informed of the resolution and its contents by letter, and appropriate publicity appeared in *Michigan Medicine.*

Res. 40 — Revision of Michigan's Abortion Laws. This resolution directed that MSMS work toward the revision and liberalization of the Michigan abortion laws. The House adopted a recommendation of the reference committee that an MSMS ad hoc committee formulate a position statement on therapeutic abortion and report its findings to the House at the 1968 session.

The special committee has been appointed and will make its report to the House.

Res. 41 — Inclusion of MDPAC in MSMS Dues Billing. As directed by the resolution, the MDPAC donation was included in the MSMS dues billing with a note that this portion is voluntary and not deductible.

Res. 42 and Res. 49 — Separate Michigan Department of Health Covering Health-Related Activities. These resolutions directed that MSMS contact the Governor informing him in the most forceful way possible that MSMS supports the retention of health-related activities within a strong separate Michigan Department of Public Health.

Immediately following the House of Delegates meeting, a letter was sent to the Governor, presenting in some detail and in a forceful manner the MSMS views on this subject. The Governor felt that a merger of the State Department of Public Health and of the State Department of Social Services at present would be inappropriate.

Res. 43 — Support of AMA Policies on Health Services. The House took no action on this resolution.

Res. 44 — Joint Billings of MDPAC Contribution with MSMS Dues Statement. (See implementation of Resolution 41 above.)

Res. 45 — Contracts for Physicians' Services. This resolution was disapproved by the House.

Res. 46 — Medical Student Preceptorship Program. This resolution directed that MSMS, in cooperation with the three Michigan medical schools and their SAMA chapters, establish a preceptorship program throughout the state.

The Council referred this resolution to the Education Liaison Committee. The possibilities of establishing a preceptorship program as requested by the resolution are under study by the Committee and representatives of the three medical schools. In effect, this is a continuing study (which has many ramifications) of a preliminary investigation several years ago by the same Committee.

Res. 47 — Local Responsibility for Health Programs. The resolution specified two kinds of action: 1) That MSMS charge component medical societies with the responsibilities of establishing effective lines of communication with the local health departments and local chapters of all voluntary health organizations and agencies, and 2) that MSMS urge component medical societies to periodically inform the agencies and organizations that the component medical societies recognize their responsibility in all health programs, screening programs, etc.

A letter developing the intent of this resolution was sent to every component medical society; and related letters were sent during the year dealing with such specific matters as component society involvement in disaster emergency medical care planning, health manpower and recruitment, etc.

Res. 48 — Wayne State University Centennial. The resolution directed MSMS to present an award to WSU honoring the WSU Centennial and to call the centennial to the attention of the AMA House of Delegates. The AMA concurred in an MSMS-sponsored resolution at the winter AMA House of Delegates meeting, recognizing the WSU Centennial. A framed copy of the 1967 MSMS House of Delegates resolution was presented to WSU during its centennial observance in the spring.

Res. 49 — Separate State Health Department. (See implementation under Res. 42 above.)

Res. 50 was withdrawn by the introducer.

Res. 51 — Driver Capability and Re-Evaluation for Licensure. This resolution directed MSMS to "offer its services to the Legislature and the Secretary of State in an advisory capacity to assist in the development of means whereby a fair evaluation of driver capabilities may be accomplished permitting the restriction or withdrawal of driving privileges from those judged to be physically or mentally incapable."

Attempts by the Highway Injuries Committee and the Legal Affairs Committee to secure legislation were unsuccessful. However, the matter is still under consideration by the Secretary of State's office for 1969.

Res. 52 — Physician Representation on Hospital Governing Boards. This resolution stated that hospital boards of trustees should have adequate medical representatives. The intent of this resolution was transmitted by letter to the Michigan Hospital Association. In response MHA indicated that it agreed that improved communications were necessary, and that it favored the joint conference committee approach, whereby chairmen of the different medical services and the chief of staff meet with an equal number of representatives of the Board of Trustees and the hospital administrator.

Res. 53 — MSMS Support of 1968 Student American Medical Association Meeting in Detroit. The resolution directed that The Council and staff extend all possible cooperation and support to this SAMA convention.

After consultation with SAMA officials, The Council authorized a $500 program grant and staff assistance to SAMA for this national meeting.

Res. 54 — MSMS Liaison with Students of the Health Care Professions. This resolution directed appointment of a liaison committee with students of the health care professions in order to extend the availability of medical care.

The Council requested the Liaison Committee with Residents, Interns and Medical Students to implement the intent of this resolution. The Committee is now studying possibilities for extending liaison with students of the health care professions, in order to appropriately implement the resolution.

Res. 55 — Antidiscrimination in the Michigan State Medical Society. This resolution proposed an amendment to the MSMS Bylaws adding a sentence, "There shall be no discrimination on the basis of race, religion, sex, or ethnic origin."

This change was incorporated in the 1967 revision of the MSMS Constitution and Bylaws.

Res. 56 — Development of Physicians' Hospital Privilege Act. The House instructed the Legal Affairs Committee to study the feasibility of developing a Physicians' Hospital Privilege Act embodying the intent of the AMA resolution that all doctors of medicine be accorded hospital privileges commensurate with their training, experience and competence.

A Legal Affairs Committee special study group has concluded that such a law would not be feasible. It is recommended, however, that the House of Delegates again reaffirm its position that no ethical physician should be refused staff privileges for reasons of race, creed or color.

Res. 57 — Creation of an MSMS-Sponsored Academy of Medical History as a Division of the Historical Society of Michigan. Alfred H. Whittaker, MD, a member of the MSMS Committee on Michigan Medical History and introducer of the resolution, is working with the Michigan Historical Society to establish a medical history branch within that Society.

Res. 58 — Clarifying Michigan Law to Safeguard Privileged Character of Medical Records. This resolution directed that MSMS work with the State Bar and the Legislature to clarify and strengthen Michigan laws and court rules re safeguarding the privileged character of medical records.

A subcommittee of the MSMS Liaison Committee with the State Bar of Michigan has been appointed and will meet soon with a State Bar subcommittee to study this matter.

Res. 59 — Appeal Mechanism for Unresolved Adjudication. This resolution directed MSMS to establish an appropriate appeal mechanism available to MMS or the physician concerned in cases of unresolved adjudication.

The Council adopted an opinion of the County Societies Committee that adequate appeal mechanisms already exist and that our knowledge of the existing machinery should be routinely made available to carriers other than Blue Cross-Blue Shield. In The Council's view no further action need be taken.

Res. 60 — Acceptance of Osteopaths as Residents and Interns. This resolution directed that the AMA Council on Medical Education be requested to amend its position so that osteopathic graduates might be accepted as residents and interns.

This resolution was brought to the attention of the AMA Council on Medical Education by letter shortly after the House of Delegates meeting and subsequently a Michigan resolution to this effect was introduced into the AMA House of Delegates at its June, 1968, meeting. The AMA resolution was referred to the Board of Trustees and the Council on Medical Education for consideration.

Res. 61 — Health Council's Silver Anniversary. The House of Delegates commended the Michigan Health Council (and the various foundations which contribute financial support) for its "past accomplishments and present programs." The Council presented a citation (officially explaining the action by the delegates) to the Health Council during the midsummer meeting at Mackinac Island, when Health Council officials met with The Council for presentation of their annual report.

Res. 62 — Commendation of Retiring Director of Michigan Department of Public Health. The House suspended the rules and adopted this resolution by a rising vote. The resolution recognized "the distinguished and outstanding service" of Doctor A. E. Heustis, retiring director of the Health Department. An illuminated copy of the resolution was presented to Doctor Heustis upon its adoption.

Res. 63 — Appreciation to Speaker Lightbody. The resolution called for appropriate recognition of the fine service by Doctor Lightbody as retiring Speaker of the House of Delegates. A framed pen-and-ink sketch of Doctor Lightbody with a small printed note of appreciation under the sketch was presented to Doctor Lightbody at the Midsummer Session of The Council.

Res. 64 — Commendation to Vice-Speaker Hayes. The resolution asked that a suitable commendation be presented to Doctor Hayes as retiring Vice-Speaker of the House. A framed copy of the resolution was presented to Doctor Hayes at the MSMS Conference on Health Care Planning in Detroit in February.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the Report and commended the Speaker for the printed Summary.

6. Remarks of AMA President-Elect G. D. Dorman, MD

Doctor Dorman addressed the House on the subject of "Unity in Medicine."

7. President's Address — Bradley M. Harris, MD (extracted)

The federal establishment has an ever increasing role in medical care. We must continue to be alert and interested and provide leadership in the programs which concern federal medical legislation. Within the next two months we will elect a new House of Representatives and a new president. I realize that I am repetitious but I cannot urge you too strongly to become actively involved both financially and physically in both the national and state political campaigns. The 90th Congress is examining Medicare in terms of cost and need and there will be changes in regard to administration of the programs. We have a vested interest as physicians, as well as taxpayers, in this legislation. It behooves each of us to make our views apparent to the candidates. The Heart Cancer and Stroke program has expended something over a million dollars in Michigan to date without visibly influencing the care of any significant portion of the population. This is intended to provide, among other projects, a continuing educational program directed to the practicing physician. Our Society has conducted in collaboration with our medical schools a very successful program for many years. The opportunity to expand and intensify these efforts would appear to be the most immediate and feasible method at this time.

I would urge a closer liaison between the director of the program and our Postgraduate Committee to the end of early development of this available source of dissemination.

Medicine is a proud profession and I am certain it will always be. But we are not too proud to ask the help of intelligent and dedicated laymen when their assistance can aid us in increasing the quantity and quality of medical care we can offer our patients.

For some time the Michigan State Medical Society has been on record as favoring the expansion of the medical schools at the University of Michigan and at Wayne State University. Further, we have strongly endorsed the expansion of the two year medical school at Michigan State University to a four year school. Concomitant financial support through action of the Michigan Legislature is necessary.

Although there is a strong basic science program at Michigan State, and the new life sciences building and additional faculty will expand these facilities, the present great need is financial support to develop the clinical areas of the medical school curriculum to qualify as a Class A four year medical school.

I suggest that we should strongly urge the development of citizens groups to augment our appeal to the legislature to provide the support necessary to bring this program to fruition. This must be accomplished prior to any commitment to a fourth tax-supported medical school in Michigan.

At the request of the 1967 House of Delegates an Ad Hoc Committee has produced a single medical practice act which will be introduced into the next session of the Michigan Legislature. They have accomplished a monumental task. I think we must realistically recognize that this will meet with opposition. The other disciplines will most certainly resist for various political reasons, with which you are familiar.

Here again the wide spread support of citizens groups in support of a single standard in the healing arts can be of inestimable assistance.

The Ad Hoc Committee requested in Resolution 40 of the 1967 House has studied the Therapeutic Abortion Problem in depth. Their report which is before you, I feel presents an affirmative position which the Society can support without apology.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recognized the fine work of the President during the year, noted his recommendations and "particularly urged each county society to develop citizens' groups to augment our appeal to the Legislature to provide necessary support for our program" seeking expansion of MSU to a four-year medical school.

THE HOUSE adopted the report of the Reference Committee.

8. President-Elect's Address — James J. Lightbody, MD (extracted)

This is the first opportunity I have had to express to this House of Delegates my deep appreciation for the privilege of being your Speaker of the House for the past eight years and as Vice-Speaker for three years before that. During those eleven years as an officer of this House of Delegates, I was extremely fortunate to have had the opportunity of working with some very fine and capable men. During my three years as Vice-Speaker, Doctor Ken Johnson was the Speaker of the House, and he taught me a great deal about motions, amendments, and amendments to the amendments — and also how to handle people who were partly or completely out of order. Ken Johnson and I had an exciting three years together.

During my eight years as Speaker of this House, I was also very fortunate to have the services of three capable colleagues as the Vice-Speaker — John Rice of Jackson — Harold Falls of Ann Arbor — and Lou Hayes of Gaylord.

I want to thank these men at this time for their able assistance and I am sure we are all very sorry that because of added professional responsibilities, they chose not to continue on as Speakers. This brings us up to the present, and the administrative affairs of this House are now in the very capable hands of Jim Blodgett, of Detroit, and Vern Bass of Bay City — I wish them continued success.

The Michigan State Medical Society is now 103 years old, and there are times when I feel that I have been a member all of those years — then there are many other times when I feel excited, rejuvenated, and highly enthusiastic about our present and future plans and programs.

There is, at present, an acute imbalance between demand and supply of physicians to serve the ever-increasing population of our urban areas. Medical schools are attempting to face this problem by increasing the number of admissions to medical schools and also by making certain changes in their curricula. We also know that an increase in the supply of physicians alone will not solve the dilemma. We see an imbalance in our physicians' pool because of the increase in the number of young physicians who are choosing research for their major interest, so this obviously affects the supply available for patient care. Another reason for the shortage is that about 10% of licensed physicians in this country are now working in the armed services or in administrative positions.

The answers may come by developing greater utilization of the allied health scientists and other paramedical personnel — and with the increased popularity of so-called "group practice" to decrease the strain on individual practitioners.

There is going to be more and more impersonalization of patient care, and this means that the traditional face to face confrontation of patients with physicians may be on a limited basis in the future.

One of the matters of great current interest to the Michigan State Medical Society is its relationship with the Negro physicians in this state, and this, I believe, is a major challenge and should be squarely met with the indorsement of a coordinated, bilateral program to improve our communications with the Detroit Medical Society and the National Medical Association. Negroes constitute 11.4% of the nation's population, but have only 2.2% of the nation's physicians. According to a recent report released by the American Association of American Colleges, approximately 300 Negro students are expected to enter United States medical schools this fall. This represents a 50% increase over the situation five years ago.

The majority of Negro physicians have felt that the American Medical Association did not have a realistic motivated program to assure better care for Negro patients and did not fully comprehend the professional load that the Negro physicians of this country were carrying in attempting to take care of the great number of Negro patients. The difficulties that some Negro physicians have had in gaining hospital staff appointments is well-documented, but this is also true of some white physicians.

Negroes have served in the Volunteer Physicians for Vietnam Program — They have served in the Armed Forces Medical Corps — and have served aboard the steamship Hope and have actively participated in many local and national health programs. Michigan was recently honored by having Doctor Lionel Swan as President of the National Medical Association, and Doctor Swan is a member of our State Medical Society.

Another milestone in this area of interest, was the action of the American Medical Association House of Delegates in amending their Bylaws so that constituent societies might have their charter revoked if found guilty of racial discrimination.

The importance of the entire problem was highlighted at the recent annual meeting of the National Medical Association where President Lyndon Johnson put in a surprise appearance and spoke to their House of Delegates.

Specifically, I would suggest that state and county medical societies re-evaluate their interests in programs affecting the medical care of both the black and white poorer segments of our urban areas particularly, and make every effort to improve the professional relations of Negro physicians in all areas of health activities.

I feel, however, that Negro physicians themselves should make a greater effort to participate in county and state medical societies' programs and activities so that we can eventually eliminate any racial inequities that may now exist.

The education of the physician is an endless process — and we should continue to encourage medical education at all levels beginning in the medical schools and continuing through all postgraduate levels into specialty societies and hospital education programs. We now have three medical schools in this state and their postgraduate programs are of the highest caliber.

We should also continue to support the activities of the state and local health departments as their activities many times overlap with our own health programs concerned with direct patient care. Another matter of major concern is the care of the older people who are chronically ill. We must see the older patient as one of the great challenges in medicine rather than a candidate for custodial care. First class care for older people will lead to improved, preventive measures for younger ones. This frequently involves participation of county, state and federal programs, but this is going to be an expanding area of activity in the years ahead and the medical profession must concern itself in cooperating with and giving direction to public agencies.

The scientific progress of medicine — its skyrocketing per diem costs in hospitals — and the mounting shortages of personnel to deliver high quality medical care are causing far-reaching changes in the traditional doctor-patient personal relationship throughout the whole spectrum of health service. The benefits of latest medical techniques can be delivered only through the inter-action of many specialists, and that in itself inevitably introduces an element of impersonality in the way the patient is treated.

It is fashionable in some quarters to level a constant barrage of criticism at physicians. Doctors are blamed for all the ills of society from juvenile delinquency to air pollution. This is both unjust, unfair and not based on the facts. The so-called "image" of the physician is still considered to be the highest and best of the professional and nonprofessional groups. American physicians should be congratulated on their outstanding cooperation with the "Medicare" program. The medical profession, with rare exceptions, has accepted the verdict and has worked hard to make the Medicare program an outstanding success.

The new direction in which American medicine is going is not necessarily bad because it is different. William Osler wisely said: "The philosophies of one age become the absurdities of the next, and the foolishness of yesterday has become the wisdom of tomorrow."

Let us hope that in the year ahead, that we, as physicians, will continue to give the best medical care possible to all segments of our population. The changes we are seeing in medical practice and hospitals are medical expressions of the same changes that will occur in education, industry, government and in the entire social landscape.

The transition of our medical care system simply mirrors the transition of our whole society. Let us hope that this transition will bring some degree of stability — and perhaps, some degree of tranquility.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, noted that Dr. Lightbody had many constructive programs planned for next year and approved of his suggested courses of action.

THE HOUSE adopted the report of the Reference Committee.

9. Address of Woman's Auxiliary President — Mrs. W. G. Gamble, Jr., (extracted)

Our component auxiliaries are small and large, social as well as service organizations, but all have a common denominator — members have demonstrated their concern for people and their communities by participation in various medically oriented projects.

Priorities stressed this year were: Legislation, Health Careers, AMA-ERF, and a new committee, Home Centered Health Care. With an overall concern for membership, there was an increase of 85, bringing the total to 3,566 members. By supporting various fund-raising activities, the counties have continued their support of the American Medical Association Education and Research Foundation with a total contribution of $20,964.82. Macomb County received an achievement award at the National Convention — the third such award this County has received.

One of the first states to appoint a Home Centered Health Care Chairman, we are proud to report our own county, Bay-Arenac-Iosco, initiated a Mobile Meals program on April 1.

Over $18,000 for scholarships and loans for paramedical careers — over 50 Health Career Clubs in the State — 11 Health Career Days sponsored by auxiliaries indicate the response to the challenge in Health Careers. The Careers Mobile toured again in some counties with members assisting as guides or in whatever capacity requested.

International Health Activities again proved to be a popular project, with approximately 30,000 pounds of pharmaceuticals and equipment collected for various outlets, with World Medical Relief the main beneficiary.

With the assistance of MSMS, the Auxiliary held its first Legislative Day in March. In addition to State officers and chairmen, all county presidents, presidents-elect and legislation chairmen were invited to the day-long program which began at MSMS headquarters under the direction of Mr. Riley. Then, a trip to the Capitol where appointments had been arranged for each Auxiliary member to meet with either her representative or senator. This informative program was exceptionally well received, and attending members feel better prepared to assist physician husbands in influencing good legislation in the Health field.

Community Health's large umbrella has covered a wide range of programs: The film, "Parent to Child About Sex," has been extensively shown; assistance with immunization clinics, Headstart programs, and distribution of Health Education materials, *Today's Health* and *Health Guide*. Interesting safety programs have been on "Flammable Material," "Air Pollution" and "Self Defense."

We look back over the year with pride in the many accomplishments of our county Auxiliary members. Necessarily, we must add, wistfully, our wish for more active members.

Communications always seem to be a roadblock. Do you know what the Auxiliary is doing in your community? Have you invited your county auxiliary president to report at an executive committee meeting of the county medical society? Are you personally in favor of your wife actively working in the Auxiliary? We hope the above will be answered in the affirmative.

The Auxiliary is an organization whose goals and objectives have been clearly defined. Our main purpose is to assist the MSMS in its program for the advancement of medicine and health education. We can only fulfil our objectives with your total support.

We have kept our membership informed with our State newsletter, *The Auxilium,* issued quarterly. In addition, the pages of *Michigan Medicine* contained five articles about Auxiliary participation in activities we thought would be most interesting to physicians.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, noted the many accomplishments of the Auxiliary and commended it for its activities during 1968.

THE HOUSE adopted the report of the Reference Committee.

10. Remarks of Michigan State Medical Assistants Society President — Mrs. Nelda Gasperson (extracted)

The Michigan State Medical Assistants Society is again well represented on the national level this year. Mrs. Betty Lou Willey was elected Speaker of the House and is candidate for this office this year. Several MSMAS members serve on AAMA committees. These include Mrs. Dorothy Brandis, member of the Resolutions Committee, and Miss Donna Hislop, CMA, a member of the Certifying Board. Miss Phyllis Marquardt, CMA, and Doctor Millard assisted in an approval program of the Medical Assistants Course at the Traverse City Junior College on behalf of the AAMA.

In November, 1967, the County Officers and Committee Chairman Conference was held in Lansing with a total registration of 121 members.

Miss Phyllis Marquardt, CMA, Public Relations Committee Chairman, represented MSMAS at the Silver Anniversary meeting of the Michigan Health Council. The Eleventh Annual Educational Seminar was held in Flint with an attendance of 150. Mayor Floyd J. McCree of Flint welcomed the group and proclaimed April 21 as "Medical Assistants Day."

Our Summer Seminar was held at Boyne Highland Lodge with 180 registered — the largest attendance ever for a Summer Seminar. This meeting was hosted by the Washtenaw County Medical Assistants Society.

Membership in MSMAS as of June 30, 1968, is 752, an increase of 13 since June 30, 1967. Gratiot County will be presented with its organizational charter this year and if Barry County has had its Constitution and Bylaws approved it too will receive its charter.

Our Bulletin, published quarterly, was awarded first place in the AAMA annual award contest in 1967.

A grant of $500 from The Council of MSMS to our Education Committee was gratefully acknowledged. This grant will aid the committee in establishing a survey of community colleges and subsequent standardization of medical assistants training programs offered by the colleges.

Many thanks are directed to MSMS for the use of the headquarters for our Board of Directors meetings and to our advisors G. E. Millard, MD, F. C. Cretsinger, MD, W. T. Davison, MD, and B. H. Alford, MD, for their direction and advice.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, praised the activities of the Medical Assistants and recommended approval of the President's Remarks.

THE HOUSE adopted the report of the Reference Committee.

11. Progress Report on the MSMS Judicial Commission — D. N. Sweeny, Jr., MD, Chairman

The Commission has met quarterly and on call for emergency matters. I would like to discuss only six of the problems which we have dealt with in the past 12 months.

1. *Election of Councilors.* The Commission spent much effort on problems concerning eligibility for membership on The Council of the Michigan State Medical Society. This problem stemmed from a complaint received by the Commission shortly after the last session of this House when previously established rules were changed. The action and recommendations in this regard of the local county society were reviewed and accepted by the Judicial Commission.

The Commission has concluded that the chief cause of this misunderstanding and other misunderstandings involved in such matters stems from the cumbersome mechanism by which Councilors are elected. We have suggested therefore, Mr. Speaker, that it would be advisable to amend pertinent sections of the Constitution and Bylaws of the Michigan State Medical Society anent the election of Councilors. It would seem more appropriate that Councilors be nominated and elected by the physicians of Councilor districts whom they represent, rather than by the House of Delegates as a whole. Your Judicial Commission clearly recognizes that it has no authority over the operation of the House of Delegates. We do feel, however, a deep obligation to the Society in the prevention of future complaints and serious misunderstandings of this type.

2. *Handling of Complaints by Component County Medical Societies.* The Commission is pleased to report that county societies are doing an excellent job in their handling of the complaints that are forwarded to them from the Commission. As you know, it is the policy of the Commission to have all complaints resolved at the local level whenever possible. A subcommittee of the Commission is now preparing guidelines to be used by county societies in the investigation and determination of complaints. These guidelines will be completed and sent to all county societies.

3. *Closer Liaison with the State Board of Registration in Medicine.* Your Commission has an active subcommittee working on the problem of the physically or mentally incompetent physician. We have had dialog with the State Board of Registration in Medicine in an attempt to develop safeguards so that both the public and the profession will be better protected from anyone being allowed to practice medicine in this State who is not qualified physically, mentally or professionally.

4. *Physician-Hospital Relationships.* Your Judicial Commission is deeply disturbed by the increasing number of squabbles that mar the otherwise harmonious relations between hospital administrations and the medical staffs. The Commission was helpful in resolving a serious problem that had developed in Detroit in this context. We understand a resolution dealing with this subject has been introduced at this session of the House of Delegates, and we urge its most serious consideration by the delegates.

5. *Relationships Between Doctors of Medicine and Doctors of Osteopathy.* The Judicial Commission rendered an additional opinion to a local county society that it is ethical for a doctor of medicine to associate in practice with a doctor of osteopathy providing the osteopath in question practices scientific medicine. As you know, this opinion is consonant with the opinions of the AMA Judicial Council and the MSMS policy concerning doctors of osteopathy that was established by the MSMS House of Delegates in 1964.

Our opinion, however, contained an important proviso that all information reaching the public regarding such an associate must clearly indicate that he is a doctor of osteopathy and not a doctor of medicine.

6. *The Ethic of Incorporation by Physicians Under the Michigan Professional Corporation Statute.* Upon request of a county medical society, the Commission has proclaimed that professional corporations are ethical, since

such associations are covered under an earlier determination of the AMA Judicial Council, and that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, and other lawful groups, providing that the ownership and management of the affairs thereof remain in the hands of licensed physicians.

I will not detail any of the further complaints that have come before your Judicial Commission.

Mr. Speaker, the Commission's work would not be possible without the help of our staff coordinator, Mr. Richard Campau. Because of the implications of due process and abrogation of the right to earn a living in many of the complaints received by the Judicial Commission, we could not function nor do we intend to try to function without the personal guidance of our Legal Counsel, Mr. Stewart Kerr. I am privileged by my position as Chairman of the Judicial Commission to publicly thank these gentlemen for their help.

I speak, Mr. Speaker, for your Judicial Commission, composed of the following doctors: Harold Furlong, Vice Chairman; Sherman Andrews; Louis Bailey; Norbert Scholle; Robert Hamburg; Willis Huron; Robert Powers; R. W. Teed, and Hugh Fuller.

THE SPEAKER stated that this was a progress report of the Commission for information and would not be referred to a reference committee.

12. Report of Michigan Delegation to the American Medical Association — Luther R. Leader, MD, Chairman

Doctor Leader summarized a 15-page printed report on the June meeting of the AMA which had been distributed to the Delegates in advance.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, complimented the Delegates on their work and received the report for information.

THE HOUSE adopted the report of the Reference Committee.

13. Remarks of Michigan Medical Service Board Chairman — John M. Wellman, MD

The report of Michigan Medical Service consists of three items:

1. The Michigan Medical Service Report of 1967, which is contained in your Handbook under the title "Program for Progress," was mailed to each physician in the State of Michigan in the spring of 1968. This covers in detail our activities for the year 1967.

2. Included in your Handbook is our Annual Report to The Council and the House of Delegates as of this date. In essence this consists of a resume of the reports which we have made periodically to The Council since the last meeting of the House. It also summarizes our operational activities for the first six months of 1968. It includes actions taken on resolutions adopted by the House of Delegates in 1967 which were referred to Michigan Medical Service, and finally some comments about the future role which prepayment plans will play in the field of medical economics. (Reprinted below)

3. In support of this report for the first six months of 1968, you have received today a pass-out reiterating the basis for payment under the Michigan Variable Fee Program and an explanation of the determination of reasonable charges.

We appreciate the opportunity to present these reports for your consideration.

14. Annual Report of Michigan Medical Service — John M. Wellman, MD, Chairman; John C. McCabe, President

The work of Michigan Blue Shield in 1967 was outlined in our report to The Council and House of Delegates in September, 1967. Details were published this spring in the Annual Report, entitled "Programmed for Progress."

The latter report reflected Blue Shield's continuing growth and highlighted the finalization and preparation for implementation of the Variable Fee Program.

The year 1967 was one of progressive change as well as of productive Blue Shield activity. It was characterized not only by significant enrollment increases in regular programs and the number of Michigan citizens served under government programs, but also by an increase in claims submissions due primarily to Medicaid, which nearly doubled its total volume of 1966.

This present report is intended to inform The Council and the House of Delegates concerning Blue Shield activity from January 1, 1968, through June 20, 1968.

The MVF Program

The most significant and concerted effort of the first half of '68 concerned the finalization of our planning and implementation with respect to the new Michigan Variable Fee (MVF) Program.

In addition to many operational activities, both internal and external, this implemental process involved consideration of the reaction and the degree of satisfaction of the publics served by Blue Shield, both professional and consumer. On the professional side it meant describing and explaining the new payment mechanism which involved not only higher payment levels but understanding and acceptance on the public's part.

The slow rate of participation especially among M.D.'s continues to be of concern. While the overall percentage of physicians in the State who participate with Blue Shield rose from 56.4% in January '68 to 65.7% as of June '68, the rate of growth on the part of the medical profession has lagged behind other participating professions. As an example, M.D. participation went from 60.6% to 61% for this period, while participation by Osteopaths went from 44% to 67%.

There is satisfaction, however, and significance also, in the fact that the first six months of '68 has seen a marked reduction in the number of resignations by participating physicians. For instance, only two physicians resigned during the month of June.

Enrollment

The groundwork for the MVF enrollment effort was laid in the summer and fall of 1967.

At the end of June, 1968, and prior to formal presentation of the MVF Program to the general public, 20,265 MVF contracts were put into effect, representing 286,260 members. This number did not include major accounts scheduled for conversion to MVF following the June 30 date.

Despite the increased costs which occur in some cases currently and the prospects of higher costs in the future, public acceptance of the program has been most gratifying.

Including individuals with Complementary coverage, over 3,500,000 people or 80 percent of Michigan Blue Shield's membership will be under the MVF programs by the end of 1968.

Charge Patterns

The Blue Shield benefit program for Steel Groups in August, 1967, was the first Michigan program to employ the "customary and prevailing" concept of fees for providers.

Between August, 1967, and April, 1968, there were several adjustments in screen levels under the Steel, Uniroyal, and other reasonable, customary, and prevailing fee type programs, including government programs administered by Blue Shield. These adjustments were applied to the prevailing screen data developed for upcoming MVF procedures during the first half of 1968.

The use of MRVS as a measuring and screening device for reasonable charge determination is slowly being reduced as charge patterns develop with more clarity under all programs administered by Blue Shield.

The Physician's Manual

Because of the complexity of the changeover from M-75 to the new MVF Program and the new systems and procedures which the latter required, a complete revision of the Physician's Manual was undertaken early in 1968.

The new manuals were distributed to all physicians in June, 1968. They incorporated materials and information designed to ease program transition.

The manuals include new procedure codes for MVF, plus a greatly simplified Doctor's Service Report form, together with appropriate instructions and illustrations relative to their use.

The new systems and procedures are aimed at achieving a complete integration of claims and payment procedures into Blue Shield's computer and data processing operations.

To further standardize all aspects of communications to the medical profession during and after the period of transition, the Doctor's Record was also revised completely. It was changed in size, format and typography to permit its inclusion in a special section of the Physician's Manual. The new Record, first issued in June, 1968, was designed as a primary vehicle for updating the profession about changes in benefits, procedures, and other program content.

National Account Program for Auto Groups

A major task during the final six months of 1967 and through the first half of 1968 was the development and implementation of a master control plan for the National Account Program for Auto Groups.

While activities in this regard are continuing, the following is a summary of actions through June 30, 1968:

The Master Operating Agreement was executed with Ford and Chrysler, and that for General Motors is in the process of final execution.

Plans representing the majority of Auto enrollment for Ford and Chrysler nationally signed or were committed to sign Participating Plan Agreements. Local Blue Shield Plans will be asked to sign the Participating Agreements for the General Motors account following execution of its Master Operating Agreement with Michigan Blue Shield.

Final evaluation of the Participating Plans' Physician Payment Programs, as measured against Blue Shield's acceptable criteria, was initiated.

The Michigan Blue Shield and Blue Cross Administrative Manual was distributed in accordance with the Collective Bargaining Agreement.

The program will be effective November 1, 1968.

Other Highlights

By the end of June, 1968, regular Blue Shield programs had an enrollment of 4,567,900 members. This was an increase of nearly 365,000 over membership levels in the same month of 1967. As Blue Shield entered the second half of 1968, the corporation was servicing more than 5,536,000 people in all programs, or 63.6 percent of the state's population.

The growth of Blue Shield's activities is further reflected in the corporation's financial condition at the end of June, 1968. Assets were $91.1 million, up 12.3 percent from the same date in 1967. Liabilities for the first six months of 1968 were $36.1 million, or 1.5 percent higher than the same period in 1967.

While reserves for the first half of 1968 grew to $54,961,849, the rate of growth has decreased. In the last half of 1968, the reserves are expected to be lowered as the new MVF Program is implemented and rate credit reflecting our stable financial situation takes effect.

To keep pace with the increased volume of regular and governmental business, Blue Shield increased its employee rolls to the 1,343 mark, or more than 33 percent over June, 1967.

On January 31, 1968, the Board of Directors modified existing Master Medical programs to complement the new MVF concept. At the same time the Board authorized the marketing of MVF-1 and MVF-3 Programs to Non-Group Conversion subscribers.

The administration of the Wayne County PRESCAD drug program for pre-school and adolescent children was undertaken with the approval of the Board.

Jointly with Blue Cross, Blue Shield agreed to underwrite the Major Medical (Supplemental) benefits of the Federal Employee Program. Effective July 1, 1968, the high option program, which enrolls the vast majority of those eligible, began to be administered under the Variable Fee payment mechanism, i.e., customary and prevailing, rather than fixed fee allowance.

Management implemented plans for construction of the new Blue Cross - Blue Shield service center.

Total claims submissions in all programs were 3,733,459 for the six month period. Of this amount, on a monthly basis, actual gross receipts during the period were ahead of forecast. It is anticipated that Blue Shield claims from all programs will be in excess of 8 million at the end of 1968. Regular claims receipts during the first six months of 1968 totaled 1,857,840, an increase of more than 47,500 over total claims receipts during the same period in 1967. Medicare produced 872,000 claims during the first half of 1968, indicating a 50 percent increase in such claims over 1967. Medicaid claims amounted to 1,003,619.

Benefit payments for all programs during the first half of 1968 were approximately $108 million. Of this amount $66.5 million was disbursed under regular programs, $22.3 million under Medicare, $14.8 million under Medicaid, and $4.1 million under BS-65 complementary.

Administrative Improvements

Processing time for Medicare and Medicaid claims has been substantially reduced within the past year, and particularly during the first half of 1968.

One reason for this reduction is that more physicians (approximately 68 percent during the first half of 1968) are now accepting assignments. Additionally, fewer bills are being returned because of incomplete or inaccurate information.

About 90 percent of the assigned claims are being paid within 14 to 21 calendar days after they are received.

In addition, a computer tape listing Medicaid eligibles — furnished monthly by the state of Michigan — is easing the task of verifying recipient eligibility.

Moreover, as Blue Shield experience under these programs has increased, we have been able to refine operational techniques suited to program needs and to clarify the multitude of state and federal regulations by which they are governed.

Other Refinements

Other refinements to further reduce processing time for Medicare and Medicaid claims include:

Improved training of Blue Shield staff, greater attendance of medical assistants at Blue Shield meetings around the state, and the submission of more accurately prepared claims.

The installation of a special electronic unit to permit direct-line computer communications with Social Security Administration headquarters in Baltimore and Blue Shield's resultant capability of receiving a response to data within 24 hours of its transmission to SSA.

Industrial engineering modification of Blue Shield claims processing systems and procedures, installed earlier this year, permits a greater degree of control over claims processing despite substantially increased volume.

Plans were finalized for the introduction of plastic ID cards to allow for simpler and more accurate eligibility identification, with implementation to be effective late in 1968.

Management has established a special Systems Evaluation Group whose purpose it is to react to future identifiable growth patterns. For example, a claims volume of over 10 million is forecast for 1969, and nearly 20 million by 1970.

While Blue Shield is adjusting to this enormous increase in volume, it will also be expected to keep its administrative costs at minimum levels.

This combination of needs has already underscored for Blue Shield management the necessity of designing a comprehensive "system" which will be flexibly responsive to this accelerated growth and will result in improved performance, in terms of service and costs, in all aspects of our business.

The Group's objectives are to reduce claims processing costs, shorten processing time requirements, simplify claims handling, increase claims accuracy at their origin and during processing, and establish positive processing control guidelines.

Particular attention is being given to a more sophisticated method of data transmittal from the point where care is rendered so as to reduce paper work outside of Blue Shield as well as within its structure.

Blue Shield has structured and staffed a new Medical Affairs Division which provides, for the first time, a divisional level source for staff support to management on matters affecting medical involvement.

Utilization Review Research Project

Since the inception of this project in 1967:

The project is now fully staffed and has moved into an operational phase following its initial research activity.

Activities undertaken and implemented during the first six months of 1968 include a pilot study to determine the feasibility of accumulating research data on a subscriber or user basis . . . . the beginning of analysis and programming to build a research tape record . . . . compilation of a history tape, based on selected data from the period 1959-1967, to provide a base for comparing past patterns and profiles for use in future studies.

This project is divided into three phases:

First, it will develop and demonstrate the use of computer screens for selecting cases for review by peer groups in hospital and medical settings.

Second, it will undertake the statistical development of pattern analyses and profiles from routine claims data for use by physicians and other providers.

Third, it will involve special research study projects, suggested by the Utilization Medical Advisory Committee, which will be helpful to the medical profession.

Utilization review activity, in particular the research project, leans heavily on advisory talent of both the professional and technical type.

House Resolutions: Blue Shield Actions

While many of the resolutions adopted by the House of Delegates in 1967 were of specific interest to us, only the following required Blue Shield action:

Number 32 concerning, "Participation in Michigan Medical Service:" This resolution was reported to the Blue Shield Board of Directors in July, 1968. A study is now under way to determine the effect of per case participation on the overall participation program. Until the study is completed, action on the resolution would be premature.

Number 33 concerning, "Blue Shield 'Action Line' for Medicare-Medicaid Cases:" Michigan Blue Shield's reaction to this suggestion occurred in the fall of 1967. A special handling section was established for the processing of status inquiries. The staff of the Personal Services Department was increased to render better service, and the number of Professional Relations and Telephone Service representatives was increased. In April, 1968 a new, modern Telephone Service area was constructed in the home office to speed internal handling of physician's calls. In addition, a member of the Public Relations staff was assigned to coordinate the handling of especially urgent or sensitive inquiries, and to expedite their processing in cooperation with other Blue Shield departments.

Number 36 concerning, "Proposed Blue Shield Benefits for Sterilization." This resolution was studied by the Medical Advisory Committee throughout the first six months of 1968. It recommended the inclusion of male and female sterilization, on an inpatient basis only, in the surgical benefits of the M-75 Program. This recommendation was approved by the Board of Directors at its meeting of July 19, 1968.

Audits and Reviews

The degree to which Michigan Blue Shield is susceptible to auditing and review of its business operations and activities by a variety of external agencies is not commonly known. Yet, figuratively speaking, Blue Shield's business is pursued in a fishbowl-like environment and is subject to continuing official scrutiny.

External audits are conducted on a regular basis under nine different program headings which cover comprehensively all aspects of the corporation's program activities. Separate audits are aimed at program areas in which Blue Shield functions jointly with Michigan Blue Cross.

These auditing agencies include the Social Security Administration and the Medical Services Administration, both of the Department of Health, Education and Welfare, Michigan Department of Social Services, Federal Civil Service Commission, U.S. Army - Defense Contract Audit Agency, Internal Revenue Service, Project PRESCAD officials, the Wayne County Board of Auditors, auditors representing various Employer Groups, the National Association of Blue Shield Plans, and Blue Shield's prime regulatory agency, the Michigan Bureau of Insurance.

In addition, analyses are underway by the State Legislature with respect to Medicaid costs.

The type and scope of audit involved varies from an examination of balance sheets and statements of operations, covering all operational phases, to the specific auditing of administrative expenses, building occupancy costs, rate increases, and the testing of claims payments to physicians and the determination of reasonable physician charges.

During the last six months of 1967 and the first half of 1968 we were audited or reviewed formally on ten different occasions by agencies or organizations indicated above.

This was in addition to audits performed routinely by Blue Shield's own external auditors and its internal audits department. Also, innumerable informal visitations have occurred from these and other agencies interested in our performance and techniques of administration.

Such accountability is a fact of business life to which Blue Shield management responds not simply with equanimity, but with increased awareness of its many responsibilities.

The Future

The medical economics climate continues to demand that Blue Shield demonstrate with increased effectiveness the viability of solutions of medical care problems achieved and planned in the private sector. Effective responses will not be possible without the positive cooperation of the medical profession, nor without equal support from the consumer, especially in dealing with the problems of medical care costs.

It is required that the improved performance of the voluntary prepayment system — the major target of the new Blue Shield Systems Evaluation Group project — become an increasingly preferable alternative to further and probably more far-reaching government involvement in the health care field.

In the months and years ahead both medicine and Blue Shield will be presented with new opportunities for growth and new challenges to undertake change.

The reasonable application of the variable fee concept and its prudent control are of vital concern to the future climate of medical economics and to the voluntary character of our involvement. This also involves heavy participation by the medical profession, both within the Blue Shield structure and outside it.

Michigan Blue Shield's Utilization Review Research Project, as it develops and refines new techniques and methods of utilization analysis, will provide the medical profession with valuable new tools for retaining initiative in this sensitive area.

New benefits — already negotiated in the auto industry, and to be followed by other groups, will begin to make an impact on Blue Shield activities in 1969 and in the 1970's.

Drug benefits, implementation of which will begin in the auto industry in 1969, will be gradually extended to non-autos groups beginning in 1970.

Only a limited marketing of the Home and Office program is now anticipated until 1972.

Assumed effective dates for implementing other new benefits — Physicals, Well Baby care, and Eye Refraction services — have been tentatively set to begin also in 1972.

We anticipate that in the five year period beginning in 1969 there will be a tendency for enrollment in non-motors groups to rise at a higher annual rate than the auto groups, primarily because of changing employment growth patterns.

There will be changes, too, in Medicare and in Medicaid. Although the precise nature of these is difficult to foresee, it is to be expected that some switching of benefits from Title XIX to Title XVIII will occur.

While the impact of these probable changes cannot be known we expect, in general, that overall growth of Blue Shield business will be reflected in increased payout to physicians and in the development of programs appropriately responsive to patient needs. We expect a growing negative reaction on the part of the public generally to rising medical care costs. We also anticipate greater difficulty in assuring the public that we are responding adequately to its concern about costs.

In view of these expectations, management is committed to focus its efforts even more positively upon those present realities and future needs of medical economics on which the overall effectiveness of Blue Shield programs must be based.

THE REFERENCE COMMITTEE on Health Insurance & Medical Services, R. E. Rice, MD, Chairman, noted that the report was comprised of the annual report of Michigan Blue Shield to the House of Delegates along with supplementary information in the form of the Annual Report for 1967 and the information contained in the handouts entitled "Michigan Blue Shield Variable Fee Payment Mechanisms."

The Committee recommends that the substance of this report be distributed to every physician in Michigan involved in health care and to any other interested party.

This report reveals a massive capacity to provide for monumental changes within a very short time. We can be grateful that this is so. Furthermore, we can expect that this capacity will be sufficient for greater requirements that obviously will be present in the future in the payment mechanisms for providers of health care.

The Committee would like to convey its impression that corporation has responded well to the needs of the patient in a manner compatible with the ethos of the medical profession.

Our Committee feels these reports should be received enthusiastically for information.

THE HOUSE adopted the report of the reference committee.

REPORTS OF THE COUNCIL

15. Remarks of the Council Chairman — Robert J. Mason, MD

The Annual Report of The Council in your Delegates Notebook outlines major areas of concern and the action taken by The Council in exercising its leadership responsibilities. My remarks today concern pertinent actions of The Council since the report was printed. In addition, I will make some personal observations and will call upon Finance Committee Chairman Whiteley and Treasurer Ylvisaker for some comments.

As you are aware, the full Council meets eight times a year in regular session, with special sessions as necessary. An MSMS Councilor spends approximately 17 days each year on Council business.

The Council reviews minutes of all committees and takes definitive action on them, as well as reviewing the annual summaries of these committees. Because The Council is a large group and many of the matters coming before it require detailed study, The Council is organized with three standing committees: Finance, with Robert K. Whiteley, MD, Detroit, as Chairman; County Societies, with John J. Coury, MD, Port Huron, as Chairman; and Publication, with Brooker L. Masters, MD, of Fremont as Chairman. These three Committees serve as pre-study or reference committees; they make recommendations to The Council on items referred to them. I only outline this to emphasize the fact that detailed study and deliberation is given to every action of The Council.

The Council also is aware of the concerns of the individual members of MSMS, the component societies and specialty organizations composed of MSMS members.

I need not outline for you, I am sure, the many continuing problems facing medicine. The House of Delegates, as you know, sets the policy on these matters and The Council implements policy on a month-to-month basis.

Last year, and for several previous years, the House of Delegates instructed The Council to develop a model Single Medical Practice Act. This model Act was developed by the Legal Affairs Committee; copies have been sent to the delegates and to The Council.

The Council makes no recommendation to you regarding its adoption, but wishes to remind you that this is a highly technical document and requires thorough study so that the implications and ramifications of the rather precise language are fully understood before this House adopts or amends the proposed Single Medical Practice Act. I am sure you will seek the advice of MSMS Legal Counsel, representatives of the State Board of Registration in Medicine and, of course, members of our Legal Affairs Committee during your deliberations.

Another matter of concern in recent years has been professional liability insurance. Last year, you will recall, The Council issued a white paper on this matter to inform the members of the growing problem of malpractice claims in Michigan. The situation, as predicted, has steadily worsened, to the extent that The Council instructed its insurance advisor to make a thorough study of the malpractice field and give his recommendations on what course of action MSMS could or should take.

Briefly, he recommended that MSMS consider initiating a Society-sponsored professional liability insurance plan. The Council instructed the Professional Insurance Committee to thoroughly investigate this proposal and to present its recommendations to The Council. The report of the Committee, which was received by The Council yesterday, is as follows:

Special Report on Professional Liability Insurance

As instructed by The Council this Committee has investigated the proposed program of MSMS-sponsored professional liability insurance as presented to The Council in July by Insurance Counsel Stratton and Employers' Group of Insurance Companies.

The Committee invited similar proposals from the 28 largest multiple life casualty companies of which 23 replied that they would not be interested in offering a sponsored plan. The remaining 5 companies did not reply.

Finally, discussions were held with representatives of the Employers' Group and the Medical Protective Company. Our investigation disclosed the following facts:

1. Approximately 80% of MSMS members are now insured by the Medical Protective Company.
2. Medical Protective has found it necessary to decline many new applications from Class 5 physicians (these include Anesthesiologists, Neurosurgeons, Obstetricians-Gynecologists, Orthopedists, Otolaryngologists-Plastic Surgery, and Plastic Surgeons).
3. Medical Protective has also found it necessary to discontinue the writing of physicians who practice in some remote areas of the upper peninsula.
4. Medical Protective is not interested in becoming involved in a MSMS-sponsored plan nor would it oppose any actions by MSMS to sponsor a plan with another carrier.
5. The A. M. Best Company, a well-recognized rating organization, shows a decline in the ratings of the Medical Protective Company as follows:

Year	Rating*
1964	A
1965	A
1966	B+
1967	B+
1968	B

*Best's highest rating is "A Plus" and this denotes a general policyholders rating of "Excellent." Ratings vary from "A Plus" (Excellent) to "C" (Fair). The ratings used herein were taken from the latest Best's Guide. A higher rating indicates greater ability to meet present and future obligations.

6. The Employers' Group of Insurance Companies has successfully engaged in a Florida Medical Association sponsored plan of Professional Liability Insurance since 1962.

   The experience of the Florida Medical Association with Employers' was thoroughly researched by Richard Campau, the Committee staff assistant. He reported that Florida Medical Association is extremely happy with the performance of Employers' Group especially in regard to the following points:

   A. Aggressive claims defense on a statewide basis.
   B. Excellent cooperation in claims defense through committees of the Florida Medical Association and its component county societies.
   C. Educational programs for physicians as to underlying causes of claims and how to avoid them.
   D. Premiums have been kept competitive with other carriers.
   E. No physicians have been denied coverage because of specialty or location of practice.
   F. Outstanding defense counsels have been retained.
   G. Employers' has maintained the plan on a sound experience rating basis.
   H. The Company has provided the Association with complete information concerning claims and settlements.
   I. The Employers' policy specifically states that professional liability includes service by the individual insured as a member of a formal accreditation or similar professional board.
   J. In addition to its basic professional liability policy, Employers' also offers an "umbrella" type liability insurance at a reasonable premium.

Based upon the above findings and other information the Committee has concluded as follows:

1. The policy proposed by Employers' is broader and meets the needs of MSMS members better than that issued by Medical Protective.
2. The A. M. Best rating of Employers' is A Plus whereas the same organization now rates Medical Protective as B. The higher rating of Employers' indicates its greater ability to meet present and future obligations. Employers' is an organization with assets of over 400 million dollars while Medical Protective has assets of less than 20 million.
3. Employers' would establish a close liaison with MSMS to work toward an improved medico-legal climate.
4. Employers' would vigorously defend groundless claims.
5. A much more stable market would be available from Employers' than now exists. There would be no rejections or terminations because of specialty, geographical location or age.
6. Premium rates offered by Employers' would be competitive to those of Medical Protective.

The Committee is not able to make any recommendations to The Council at this time because Employers' cannot provide a specific premium quotation as professional liability rate changes involving most carriers are pending with the Michigan Bureau of Insurance. It is the intention of the Committee to submit its recommendations just as soon as the premium situation has been clarified.

We do not have the information required to make a firm recommendation to this House at this time. Therefore, The Council recommends that the House authorize The Council to complete negotiations for an MSMS-sponsored program of professional liability insurance if it is determined that such a program would best serve the interest of MSMS members. Such authorization will mean that the House has expressed its approval of the general concept of a Society-sponsored plan and will leave the detailed negotiation to be conducted by The Council so that the plan can be instituted without waiting for another 12 months when this House will meet again.

Since the special session of the House of Delegates in February, The Council has supervised every detail of the implementation of the new Asset Management Plan. We have faithfully followed the plan as adopted by the House, and I believe the report of your Treasurer will be of extreme interest. The Council certainly compliments Treasurer John Ylvisaker for his devoted leadership.

As I have told you, one of the key committees of The Council is the Committee on Finance, chaired by Dr. Whiteley. Dr. Whiteley will present a brief picture of our financial condition and then will introduce Treasurer Ylvisaker. Following Dr. Ylvisaker's presentation I would like to make some personal remarks to the House.

ROBERT K. WHITELEY, MD: 1968 has not been the most stable year in our nation's economy, as I am sure your office practice indicates. It has been a difficult year for MSMS, too. The cost of doing business is up; income is up; increased expenses are outpacing income.

Fortunately, MSMS three years ago had the foresight to initiate a modern, efficient, intelligent money management plan which gives the Finance Committee and The Council the ability to exercise rigid budget controls. The effectiveness of this plan is evidenced by the fact that actual expenses last year were within 1 per cent of budget. The Financial Structures Committee of the House has made a thorough study of our financial condition and a copy of that report has been distributed to you. We have projected our budgets for 1969 and 1970 and the results of those projections are in the Financial Structures Committee report.

I don't believe I should in a verbal report such as this give you just a bunch of figures. I will be prepared to discuss any detail of the budget and our income statement at the reference committee meeting. I do want you to know, however, that the Finance Committee and its professional consultants are prepared to meet the Internal Revenue Service regulations regarding the reporting of *Journal* advertising income. We believe that the formula for allocating expenses and income, developed for us by the Alexander Grant Company, is adequate to meet IRS demands. We are similarly prepared following the publication of guidelines for reporting exhibit income.

Now I would like Dr. Ylvisaker to give you more details about the Asset Management Plan.

Report of the Treasurer

My report this year is in two major parts and concerns itself with:

I. The Asset Management Program adopted by The House of Delegates in Special Session, February, 1968.

II. The financial condition of MSMS.

Part I

In brief review, the new Asset Management Program adopted by the House authorized the following:

1) Mortgaging of the MSMS headquarters building in an amount up to $650,000 at 6¼% interest, 25 year term, free of mortgage fees and prepayment penalties.

2) Application of the resultant monies a) to eliminate short-term line-of-credit borrowing for operational expenses, b) to increase existing reserves of $125,000 to $250,000 and thereby to establish a permanent Capital Reserve Fund with specified guidelines for use and maintenance, and c) to establish a Capital Protection and Creative Reserve Fund with the balance of the proceeds, the purpose of which would be to provide funds for other-than-ordinary services to the Society and for creative Society projects consonant with the stated aims and objectives of the Society.

3) Establishment of a Board of Managers consisting of five members with authority to invest and manage the Capital Reserve Fund and the Capital Protection Fund, subject to basic control by The Council.

4) Investment of funds as follows:
   a) Capital Reserve Fund — 50% in fixed dollar maximum yield money instruments and 50% in high grade negotiable securities to provide stability, income and conservative growth.
   b) Capital Protection and Creative Reserve Fund — 100% in bona fide investment vehicles to provide growth within the limits of sound fiscal judgment and income appropriate to such growth.

Subsequent to this authorization, The Council and your Treasurer proceeded with the implementation of this plan. The mortgage was closed with the Michigan National Bank in March. The Council then established a Board of Managers consisting of five members:

John R. Ylvisaker, MD, MSMS Treasurer	Term 1 year
Robert K. Whiteley, MD, Chairman, Finance Committee	Term 1 year
Ross V. Taylor, MD, physician representative	Term 1 year
C. Allen Payne, MD, physician representative	Term 2 years
Thomas H. Wagner, investment counselor	Term 1 year

The Board of Managers met on four occasions to transact necessary business including:

1) The establishment of a specific and objective format of operation.

2) The designation of Merrill Lynch, Pierce, Fenner & Smith, through its Institutional Department, to provide advisory service and act as official investment broker.

3) The investment of the $125,000 existing reserves in 6¼% certificates of deposit.

4) In May the investment of the first mortgage draw of $125,000 in a balanced portfolio of high yield stocks with conservative growth orientation to complete the requirements for the Capital Reserve Fund.

5) In late June, the investment of the second mortgage draw of $100,000 in growth-oriented stocks and high yield bonds to initiate the Capital Protection Fund.

6) The investment of the third mortgage draw of $100,000 in growth-oriented stocks in September to enlarge the Capital Protection Fund.

Procedurally, the Board of Managers reports regularly to the Finance Committee which, in turn, reports its findings and recommendations to The Council for information and action where necessary. Minutes of the meetings of the Board of Managers are open to both bodies.

At present the funds have substantial gains which provide the Society with additional security.

Part II

I should like to discuss the financial condition of the Society from two standpoints: the present and the future.

With the new asset management program we are in a period of transition and are converting to what might be called a budgeted, pay-as-you-go program for annual operations backed by actual reserves adequate to our present needs. Ignoring the intricacies of this transition, we are now operating within our actual income. For 1968, our income from dues and other sources covers our expenses with a modest surplus to apply on our previous borrowings.

Henceforth, however, we are bound by a budget. We may no longer finance increased expenses with unprogrammed line-of-credit borrowing. We must live within our income. To accomplish this, we must project our budgets, we must program our projects, we must tailor our expenses to fit our income or increase our income to cover increased expenses.

Without any dues increase, our income expands at a relatively predictable rate of 1% per year. Without any new projects, our expenses increase at an average rate of 4-5% per year. Our tentative projects for 1969 and 1970 confirm these rates. Therefore, with good management and no new obligations we can operate without an increase in dues for 1969. However, let me repeat and emphasize: If we embark on new programs or assume new financial obligations, the cost must be counterbalanced by 1) reduction of existing expenses or 2) an increase in dues. The amount of increase of dues will be in direct proportion to the costs incurred. With approximately 8,000 members a $10 increase can produce only up to $80,000.

As an individual, I am strongly in favor of our Society initiating and supporting aggressive, positive, imaginative programs to ensure the best quality of medical practice, the most efficient distribution, the most equitable regulation, and the most reasonable cost of medical care in the nation. To accomplish such objectives our Society must review the status of present programs to ascertain effectiveness and productivity in relation to cost. As your Treasurer, I recommend such action.

MSMS must also be prepared to finance new creative projects. The establishment of the Capital Protection and Creative Reserve Fund I sincerely believe will become one of the greatest forces in fostering and supporting such projects in the coming generation.

ROBERT J. MASON, MD:

You have all received a copy of the workbook, *Where We Stand*, 1968. Just as its predecessor did last year, this document challenges our interest by discussing the opportunities, responsibilities and problems of our profession in the changing environment in which we practice and in which our organization functions.

Earlier I told you that a Councilor spends an average of 17 days on Council business. Yet this does not truly indicate the extent of his participation. It does not reflect the study time, the thinking time, and travel to and from meetings, which eat into a daily schedule. But these elected officers of yours deserve special praise. As Chairman of The Council, I know just how important their contributions are. I express to them, the Councilors and officers of MSMS, my sincere appreciation for their leadership and cooperation during this past year.

Our leadership responsibilities are greatly facilitated by fine staff efforts. In addition to the staff's management function, our executive, senior and secretarial staff provides background and planning help for all MSMS committees, Council committees, House of Delegates and your officers.

I want to praise the members of this House of Delegates for its policy guidance in the past. I am confident that your deliberations today and tomorrow will provide appropriate policy to meet the problems that medicine faces today.

(HOUSE action on this verbal report follows the Annual Report of The Council, see page 22.)

16. Annual Report of The Council

PART I

Report of Council Activities

This section of the report contains a brief review of the activities and actions of The Council covering the period from September 1967 through July 1968.

Minutes of the regular meetings of The Council are distributed to component medical societies and members of the House of Delegates. In addition, abstracts of Council actions appear in *Michigan Medicine*. For this reason, the details of Council actions and decisions are not outlined in this review. Instead, The Council wishes to point to a few of the major achievements and problems in a general way.

MSMS Relationship with Blue Shield. The Council appointed an Ad Hoc Committee to Study MSMS Relationship with Blue Shield and asked it to recommend what future relationships should be. The Council adopted the committee's report in July.

The Committee recommended, unanimously and unequivocably, continuation of the present relationship between MSMS and MMS, and collected the following reasons in support of its recommendation:

1) The initiation of the service concept of prepaid medical care was made by physicians of Michigan. Though there have been many changes associated with the growth of MMS over the years, the basic philosophy behind this program seemed to the Committee to remain on solid ground. It is our opinion that, while admitting that areas of dissatisfaction do exist, as with any large scale operation, in general the consumer, the purveyor and the fiscal agent have cooperated to provide a workable, generally beneficial method for servicing and financing health care in Michigan.

2) The occasional situation which has led to concern for MSMS continuing its relationship with MMS has usually been due to faulty or inadequate information and communication and/or the changing format of coverage.

The Novy report of 1960 re-established certain fundamental relationships which had become distorted. Since that time there developed a lack of adequate liaison which ultimately led to the creation of this Committee. It is to be noted that recent efforts have been made by both organizations to rectify the deficiencies and an increased awareness has developed to support the idea that we are dependent on each other's good will. With this fact your Committee heartily concurs, believing that it is more imperative than ever to further this good will relationship — with the public good our greatest concern.

3) Quoting from written notes submitted by committee members, the following comments in support of the Committee recommendation are presented:

"The Board of Blue Shield . . . consists of public lay members and representatives of medicine." It "represents the interests of its three million or so subscribers and the physicians of Michigan who provide service to the subscribers . . . The board . . . is highly sensitive to the needs of the subscriber and to the needs of the physicians of Michigan."

"The public wants and demands voluntary health insurance. This includes individual groups and large purchasers of health care. It is here to stay."

"If the medical profession through Michigan Medical Service does not provide these services — a void or vacuum will be immediately created in this vital area of providing medical care."

(These) "basic groups, namely government, private insurance carriers and hospitals (via Blue Cross) or a possible combination of all three will take over the health carrier role and set fee schedules."

"There should be an ongoing continuing investigation of the economic relationships of Blue Shield and the Michigan State Medical Society and the future role of these in the practice of medicine in Michigan."

Finance. Inflation and the generally higher cost of doing business have had a limited effect on the MSMS financial picture. Fortunately higher costs have been partially offset by increased income. This plus careful control has produced a balanced budget in fiscal 1967 and a balanced budget is predicted for fiscal 1968.

1968 has been a changeover year, during which MSMS is embarking upon the new Asset Management Plan approved by the House of Delegates meeting in special session in February. Treasurer Ylvisaker, the plan's architect, has received the highest praise from The Council for his fine work in developing the plan and in implementing it following House approval. Doctor Ylvisaker will present details of the plan's implementation status in a direct report to the House.

It is impossible to know what the next budget year will bring. We can be sure of some inflation and higher costs, especially in services. The Council, as it develops its 1969 budget, will watch closely all planned expenditures and still maintain the required and desirable level of MSMS services.

Membership. Total membership in MSMS from 1935 to 1968 was:

Year	June 30	December 31
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1966	7296	7710
1967	7301	7858
1968	7617	

Liaison with Specialty Groups. Recognizing an opportunity to be of service to the various organized medical specialty organizations, The Council appointed an ad hoc committee to review these needs. The committee will make recommendations to The Council in the near future.

Streamlining of MSMS Committees. Upon the request of the House of Delegates Committee on Constitution and Bylaws, The Council is reviewing the necessity for continuation of some committees and considering the possibility of combining or eliminating the inactive committees. Currently under study is the possibility of enlarging the scope of the Public Health Committee to include disease problems that up to now have been the concern of separate committees.

Legal and Governmental Affairs

A significant portion of the deliberations of The Council at each of its meetings concerns matters directly related to activities of the legislative, executive and administrative branches of state government and to consideration of developments related to federal health programs or congressional action.

Several members of the MSMS staff constitute a "governmental relations" team which, heavily utilizing necessary socio-economic and legal consulting personnel, are responsible for keeping The Council currently informed of significant health developments in the public sector. Perhaps most visible to the membership in this general area is the work of the Legal Affairs Committee through its news organ, "Medigram," closely followed by the Governmental Medical Care Programs Committee which frequently prepares information for publication in *Michigan Medicine*. More detailed descriptions of the activities of both these hard-working committees are contained in their Summaries of Activities as presented to the House of Delegates.

Ongoing and important work is also done, however, by such liaison committees as those with the State Executive Office, the Board of Registration in Medicine, the Mental Health Committee, the Public Health Committee and numerous liaison committees with such groups as nursing, pharmacy, podiatry, etc., all relating to gathering information for Council review or implementation of MSMS program and policy.

"Governmental relations" constitutes a total activity which increases in complexity with the passage of time, not only because of proliferating programs in the health field but because of the concomitant necessity of constantly striving to improve relationships between medicine and its allies both in the health field and in the total state community. The MSMS legislative experience in the past year has been highly successful. In addition, as our "governmental relations" staff gains experience and increases its knowledge and contacts, MSMS is steadily improving its capacity to anticipate developments, work with appropriate officials, and guide programs along the lines of Society policy as established by the House of Delegates.

Comprehensive Health Planning. Last August Governor Romney issued an Executive Order creating the Comprehensive State Health Planning Commission, to be located within his office. This body closely parallels, in basic concept, recommendations previously made to the Executive Office by The Council and the Committee on Governmental Medical Care Programs. They advocated that a plan-for-planning group be formed to formulate plans for submission to the Surgeon General for implementing this program in Michigan. Chairman of the Commission is R. G. Rice, MD, Director of the State Department of Public Health. Charles Orlebeke, an executive assistant in the Executive Office, is Vice-Chairman. Other Commission members include William H. Anderson, MD, State Mental Health Director, R. Bernard Houston, Director, State Social Services; Glen S. Allen, Jr., State Budget Director. Mrs. Betty Tableman, formerly on the staff of the State Public Health Department in Planning, was appointed Executive Director in March, 1968. Mrs. Tableman will be working under the direction of the Commission with responsibility for a continuing planning operation to identify health needs, problems, objectives, and priorities and to make recommendations for allocation of funds. Full implementation of this program has not begun, due to the difficulty of the Executive Office in appointing the required Comprehensive State Health Advisory Council. The function of the Advisory Council will be to advise on the planning process; membership must include more than half consumer representation as well as voluntary groups, physicians, public agencies, general planning agencies, and universities.

Michigan Conference for Health Planning. A new meeting, the "First Annual Michigan Conference for Health Planning and Related Subjects," was sponsored by MSMS in Detroit in February, 1968. This Conference was designed to serve MSMS members by providing authentic information by experts in several fields. The Conference revealed MSMS leadership in the critical areas of legal and legislative affairs, and medical manpower and health care planning. Major subjects covered included: The Doctors, The Law and The Courts; Legislative Affairs; Health Planning as It Affects the Physician, Hospital and Community; Comprehensive Health Planning; MARMP — Heart, Cancer and Stroke; and Public Education through a Quackery Conference. The response to this three-day conference was good and tentative plans are to continue these seminars in the future.

Michigan Association for Regional Medical Programs. MSMS has increased its involvement in the important plans for implementation of the heart-cancer-stroke program through MARMP. MSMS continues to receive the dedicated service of Don Marshall, MD, an MSMS Councilor who is Vice-President of the Board of Directors of MARMP. This federal program has made notable progress in the planning process in education and training. It is intended to 1) identify regional needs and resources relating to heart disease, cancer, stroke, and related diseases, and 2) to develop a regional medical program which utilizes regional cooperation to apply and strengthen resources to make more widely available the latest advances in diagnosis and treatment of these diseases. A regional advisory group representing university medical centers, hospitals, practicing physicians, other health professionals, voluntary and public health agencies, and members of the consumer public, will play an active role in the development of the regional program and will approve applications for operation activities of this program.

Medical Economics

Annual Revision of Michigan Relative Value Study (1965). The Committee on Relative Value Study has made revisions in the Neurosurgery, Anesthesiology and Radiology sections of the Michigan RVS. These changes will be presented for final approval as part of the Committee's 1967-68 annual report.

The Committee will also recommend that its work be continued because the RVS is a valuable reference for physicians, especially with the growth of "variable fee" type insurance and prepayment health programs.

Long-Range Planning. This project of the Committee on Medical Socio-Economics is progressing. Position papers, in which experts describe the challenges, in their view, that medicine will face, are being published in *Michigan Medicine.*

The Council is pleased to report that Charles Hall's paper on the future of health insurance and prepayment was selected by a jury representing the American Medical Association, the American Medical Writers Association and the National Association of Blue Shield Plans as the most scholarly contribution to the literature of medical economics for the year ending June 30, 1967. Doctor Hall was presented the Norman A. Welch, MD, Award by the NABSP for his achievement.

After all the papers are published, the Committee will conduct workshops throughout the state to focus attention of component medical societies on the future. This activity is intended to stimulate the development of new MSMS approaches and programs to meet the challenges of the future.

Fee Survey in Wayne County. The Council approved a request from the Wayne County Medical Society for a survey of fees in Wayne County. Work on this survey has begun and the information obtained should be of significant value to physicians, not only in Wayne County, but throughout Michigan.

Courses on Medical Economics and Ethics. Lectures on medical economics and ethics were continued at the University of Michigan Medical School under the sponsorship of the Committee on Courses on Medical Economics and Ethics. This Committee will continue its efforts to initiate similar programs at Michigan State University College of Human Medicine and Wayne State University School of Medicine.

Adoption of New Blue Cross and Blue Shield MVF-2 Package Program. The Council on June 5, 1968, approved the recommendation of the Committee on Professional Insurance Plans that MSMS adopt the new Blue Cross-Blue Shield MVF-2 package. This program replaces the present M-75 and Over-65 group health programs now available to MSMS members. It offers an expanded scope of benefits and is effective as of August 1, 1968.

Improvements in the MSMS Group Disability Insurance Plan. Several improvements in the MSMS Group Disability Plan were worked out by the Committee on Professional Insurance Plans and the Provident Company. These include: a) reduction of premium for the lowest age group (under age 34), b) an increase in the available maximum indemnity from $500 to $1,000 monthly, c) an insurability guarantee provision, d) an extension of the disability benefit period for members under age 50 who become disabled because of sickness from age 65 to lifetime.

Disability Insurance for Employees of MSMS Members. This new group insurance program was developed by the Committee on Professional Insurance Plans. This plan is underwritten by the Provident Life and Accident Company and went into effect April 1, 1968. It provides monthly cash benefits for enrolled employees of MSMS members who become disabled because of accident or sickness. A choice of a one-year accident — one-year sickness plan or a five-year accident — two-year sickness plan is available.

Medical Problems of Disadvantaged in Cities. The Council feels a deep concern that all people have an opportunity to share in the American dream of being able to better oneself by individual initiative and hard work. To this end it has appointed a committee to identify any unmet medical needs that exist among the disadvantaged in our cities and to make appropriate recommendations for MSMS action programs to meet these needs.

Updating of Statement of Principles for Lawyers and Physicians. The Council approved a recommendation of the Liaison Committee with the State Bar of Michigan that the "Compensation for services of physicians" section of the present agreement between MSMS and the State Bar of Michigan be revised to state "it is the responsibility of the attorney to pay the physician a reasonable fee for services rendered" in cases where the physician aided in preparing a case. The Medico-Legal Committee of the State Bar is pursuing approval of this change by the governing board of the State Bar.

MSMS Sponsored Plan of Professional Liability Insurance. The Council, at its July meeting, directed the Committee on Professional Insurance Plans to investigate the advisability of MSMS sponsoring a professional liability insurance program, and to report prior to the next meeting of The Council. The Council pointed out in its directive that the Committee should have discussions with the Employers' Group of Insurance Companies, the Medical Protective Company and other carriers. This investigation is underway and a full report will be made by the Committee to The Council prior to its September 22 meeting. Any recommendation to the House will be presented verbally in the Chairman's Report.

Postgraduate Education

MSMS continued to provide many postgraduate educational experiences for its members while studying possible ways to update and improve techniques and methods.

1967 Annual Session. Topics of importance to the everyday practice of MSMS members were covered by medical authorities at the 1967 Annual Scientific Session in Grand Rapids.

Michigan Medicine. This official journal offered excellent original scientific papers (mostly by Michigan men about Michigan procedures and practices) in each issue. John W. Moses, MD, Detroit, was appointed in May as the new Scientific Editor, to succeed George H. Lowrey, MD, Ann Arbor, who resigned after completing a productive term of service.

Fall and Spring Programs for Component Medical Societies. During the fall of 1967 and the spring of 1968 MSMS provided postgraduate programs throughout Michigan except for the Detroit metropolitan area. A total of 39 faculty members from the three Michigan medical schools provided 37 programs in 20 selected centers, with most centers having both a fall and spring program. The educational value of these programs was further improved this year as more communities added afternoon clinical conferences at local hospitals to discuss actual cases. The Committee on Postgraduate Medical Education during the year sought to develop some approach to determine exactly what the physicians would like to have offered, and to find out how they continue their education.

Special Conferences. To further meet its responsibility in postgraduate medical education, MSMS sponsored the Seventh Annual Conference on Maternal and Perinatal Welfare; the Annual Diet Therapy Conference in Grand Rapids; and cooperated in presenting other programs for physicians.

The Conference on Maternal and Perinatal Welfare, sponsored by the MSMS Committee on Maternal Health, with financial assistance from the Clara Elizabeth Fund, was held March 26-27 in Flint. It was an outstanding success.

Under the capable leadership of Chairman Jack W. Thompson, MD, of Flint, and his committee of Flint physicians, this year's postgraduate meeting for those persons interested in the care of the mother and her child drew a total registration of 352 — 185 doctors of medicine, 22 osteopaths, 108 nurses, 20 students and 17 guests. All in attendance highly praised the excellence of the speakers and the subject matter presented.

Professional, Public and Legislative Relations

This report highlights some major MSMS efforts in the area of relationships with the profession, the public and the Legislature. MSMS has varied activities to communicate its concerns to special selected audiences and the people of Michigan.

Liaison with Component Societies. MSMS has had effective on-going communications with leaders of the 55 component medical societies. During the fall, a traveling "faculty" of MSMS officers and staff members held workshops in four regions of the state, to inform component society officers and other leaders about actions of the 1967 House of Delegates, and to discuss current projects and problems. Throughout the year, MSMS urged every component society to send representatives to the annual MSMS Workshop on Medicine and Religion, the annual MSMS Conference on the Medical Aspects of Michigan High School Sports, and other events. MSMS also provided information and guidance to component society leaders through *Michigan Medicine* and special letters on many subjects.

Liaison with the Michigan Association of the Professions, the Michigan Health Council, and Other Organizations. MSMS officers, committees and staff spent considerable time and effort to maintain good rapport with many Michigan organizations. Liaison was maintained with a long list of organizations, including the Michigan Association of the Professions, the Michigan Health Council, State Bar of Michigan, Michigan State Pharmaceutical Association, Student American Medical Association chapters at the three universities, Michigan Nurses Association, Detroit Medical Association, Michigan Youth Commission, Michigan Press Association, Michigan Council of Churches, Michigan Adult Education Association, Michigan Congress of Parents and Teachers, Michigan Week Foundation, Michigan Public Health Officers Association, Michigan United Fund, the New Detroit Committee and many others.

Career Recruitment. The Public Relations Committee carried out many activities to inform people and their parents of the fine career opportunities in medicine and related health fields. MSMS and the Michigan Health Council purchased their second major order of "Careers Unlimited," the AMA career handbook with eight pages of Michigan information to make the booklet especially pertinent. These booklets were distributed systematically to schools, libraries, youth groups, etc. Radio tapes, TV programs, etc., all supplemented the continuing efforts of MSMS to increase the health manpower available to serve the people of Michigan.

Health Careers Mobile. MSMS (which originated the mobile unit three years ago as a traveling museum about medical progress in Michigan) continued this past year to provide major financial assistance to the Michigan Health Council's Health Careers Mobile. New exhibits on health careers were added and others refurbished. Major highlights for the Careers Mobile were extended visits at Detroit's inner-city high schools and the appearance this spring at four metropolitan Detroit Health-O-Ramas.

Special Education Efforts. The Cancer Committee carried out a comprehensive effort to get more women to have annual Pap tests; the Family Life Education Subcommittee provided speakers for many programs about sex education; the Committee on Medical Aspects of Organized Athletics cooperated effectively with the Michigan organizations of coaches, directors of physical education and others; etc.

MSMS moved into another area of major public concern — Quackery Education; it held a Quackery Workshop in Detroit during the 1968 Conference on Michigan Health Planning, and another in Lansing for selected leaders from the Legislature, federal and state agencies, health organizations, civic groups, physicians, etc. The Council in June adopted a new program in quackery to work with schools, the Legislature, and others.

Appreciation is accorded again to the Michigan Association of the Professions and its award-winning television program, "Formula." During the past year, the Formula program utilized physicians to interpret health subjects to the viewers.

PART II

Annual Summaries of Committee Activities

The Council reviewed summaries for all MSMS and Council committees.

PART III

Matters Referred To The Council By The 1967 House Of Delegates

Single Medical Practice Act. Resolution 13, which instructed that a bill to establish a single medical practice act be prepared for introduction to the Michigan Legislature and returned to the next session of the MSMS House of Delegates, was referred to the Legal Affairs Committee.

A subcommittee of the Legal Affairs Committee is working on development of such a bill for presentation to the 1968 House of Delegates.

Financial Remuneration for MSMS Officers. Resolution 17 instructed the Finance Committee to investigate the concept of adequate financial remuneration for MSMS officers, investigate suitable means of securing the additional monies required, and make a report and recommendation on this subject to the 1968 House of Delegates.

The Finance Committee studied the entire matter, including the results of an opinion survey of past MSMS officers as to their feelings on the subject based on their experience in office.

The survey showed evenly divided opinion and no agreement on the question of remuneration as to desirability, method, amount, or who should be remunerated.

The Committee also noted that current policy provides for 1) special expense allowances of $1,000 annually for the President, Speaker and Council Chairman, and 2) reimbursement of out-of-pocket expense for authorized travel of all officers.

Although the Committee felt that officer candidates were not deterred by the expense reimbursement system, it did recognize the economic impact of some of the MSMS officer positions.

Regarding the source of funds, the Committee concluded that any major program adopted could only be financed by an increase in dues.

Lastly, the Finance Committee felt it was inappropriate for it to make any recommendations on a matter which might ultimately benefit some of its members and would therefore be self-serving.

Health Information Research Institute. Resolution 18 instructed The Council to "provide for organizational expenses incidental to incorporation of the Institute, materials necessary to present the principles of the Institute to prospective sponsors and such seed money as The Council deems necessary and available within the limitation of its present overall budget."

The Council did provide "seed money" in the amount of $5,000 for the 1968 budget year. The Institute employed two part-time people to develop plans and programs and to prepare the materials necessary to seek financing from prospective sponsors.

Reports are received by The Council from the HIRI Advisory Committee and the Executive Director, and in July The Council approved an interim progress report and authorized HIRI to solicit necessary funds. Progress reports will be regularly received by The Council.

Educational Program re Chiropractic. Resolution 31 encouraged MSMS "to initiate an educational program to enlighten the general public on the dangers of the use of unscientific methods by the chiropractic cult."

Educational conferences on the broader aspect of health quackery were held in Detroit and Lansing during the past year for the public and physicians. A recommendation that there be a new ongoing "MSMS Committee on Health Quackery" to carry out an educational effort grew out of the Lansing invitation conference April 1 and was adopted by The Council in June. This committee now will seek continually to educate the public about quackery, including the cult of chiropractic.

Supporting Appropriations for Four-Year Medical School at MSU. Resolution 31 directed that MSMS support the request of the State Board of Education for an appropriation to enable MSU to expand its College of Human Medicine to a four-year medical school.

Letters indicating MSMS support of this request were sent to the Governor and other appropriate state officials, and subsequently the requested funds were appropriated by the Legislature.

Approval of Screening Programs. Resolution 35 directed that The Council limit its approval of screening programs to those previously approved by the component medical society or societies in which the program is to be carried out.

This policy was in effect prior to the time the resolution was adopted so no further action was required.

Proposed Blue Shield Benefits for Sterilization. Resolution 36 directed that MSMS through appropriate officers apprise Michigan Medical Service of the Society's opposition to the MMS restriction denying surgical benefits for sterilization procedures, and request that the restriction be eliminated.

This matter was brought to the attention of the Blue Shield Board by MSMS officers and we have been advised that MMS is studying the problem.

Medical Society Membership for Osteopathic Physicians. Resolution 39 directed that component medical societies be encouraged to offer associate memberships to osteopaths on an individual basis, and outlined provisions whereby such associate members of component societies could be admitted to associate membership in MSMS.

Component society officers were informed of the resolution and its contents by letter, and appropriate publicity appeared in *Michigan Medicine.*

Separate Michigan Department of Public Health Covering Health-Related Activities. Resolutions 42 and 49 directed that MSMS contact the Governor informing him in the most forceful way possible that MSMS supports the retention of health-related activities within a strong separate Michigan Department of Public Health.

Immediately following the House of Delegates meeting, a letter was sent to the Governor, presenting in some detail and in a forceful manner the MSMS views on this subject. The Governor felt that a merger of the State Department of Public Health and of the State Department of Social Services at present would be inappropriate.

Medical Student Preceptorship Program. Resolution 46 directed that MSMS, in cooperation with the three medical schools in Michigan and their SAMA chapters, establish a preceptorship program throughout the state.

The Council referred this resolution to the Education Liaison Committee. The possibilities of establishing a preceptorship program as requested by the resolution are under study by the Committee and representatives of the three medical schools. In effect, this is a continuing study (which has many ramifications) of a preliminary investigation several years ago by the same Committee.

MSMS Support of 1968 Student American Medical Association National Meeting in Detroit. Resolution 53 directed that The Council and staff support this SAMA convention by extending all possible cooperation.

After consultation with SAMA officials, The Council authorized a $500 program grant and staff assistance to SAMA for this national meeting.

MSMS Liaison with Students of the Health Care Professions. Resolution 54 directed that MSMS "appoint a liaison committee with students of the health care professions in order to extend the availability of medical care."

The Council requested the Liaison Committee with Residents, Interns and Medical Students to implement the intent of this resolution.

Appeal Mechanism for Unresolved Adjudication. Resolution 59 directed that MSMS establish an appropriate appeal mechanism available to either Michigan Medical Service or the physician concerned in the situation of unresolved adjudication.

After review by the County Societies Committee of The Council, The Council accepted the Committee's opinion that an adequate appeal mechanism already exists, along with a request that our knowledge of the existing machinery routinely be made available to carriers other than Blue Cross-Blue Shield.

Commendation to Vice-Speaker Hayes. Resolution 64 asked that a suitable commendation be presented to Doctor Hayes as the retiring Vice-Speaker. A framed copy of the resolution was presented to Doctor Hayes at the MSMS Conference on Health Care Planning in Detroit in February.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, 1) noted the report of the Ad Hoc Committee on Blue Shield "and agreed with their unanimous recommendation that the present relationship between these two bodies be continued. We urge that every effort to improve communications between these two groups be utilized." 2) complimented the Treasurer and the Board of Managers, 3) urged each Delegate and each component medical society make every effort to be involved in comprehensive health planning. The future of medicine for all of us is dependent on this. In testimony before the Reference Committee there was considerable feeling that an attempt should be made to amend Public Laws 89-749 and 90-174 of the U.S. Congress to increase physician representation on comprehensive health planning boards.

(4) You have all received a copy of a draft dated 9/5/68 for a Single Medical Practice Act. The Reference Committee recommends that a study committee of the House of Delegates be appointed by the Speaker to review this draft. On this committee we feel there should be representation by Legal Counsel, the State Board of Registration in Medicine, and the Legal Affairs Committee. This committee should also obtain from each county medical society a review of this draft. This committee should report to The Council of MSMS, and your Reference Committee wishes to empower The Council to approve and use the final Single Medical Practice Act as they see fit in introducing it to the Michigan State Legislature.

(5) In the supplemental remarks of Dr. Mason this morning was a report from the Committee on Professional Insurance Plans, Dr. Robert Stow, Chairman. This report deals with a proposed professional liability insurance policy to be sold on a group basis to MSMS by the Employers' Group of Insurance Companies. It is the feeling of the Reference Committee that this House of Delegates should empower the Committee and The Council to act in our behalf to obtain this group coverage once the premium quotation is obtained, if in their judgment it is in the best interest of the Society to proceed.

(6) Your Reference Committee discussed The Council action regarding Resolution 17 of the 1967 House of Delegates. The Reference Committee suggests that the Speaker of the House appoint a committee to investigate the question of remuneration of MSMS officers and report their findings to the 1969 House of Delegates.

THE HOUSE substituted for the last sentence in item 4), the following: "This Committee should report to The Council of MSMS. Your Reference Committee wishes to empower The Council to approve and use the Single Medical Practice Act as they see fit in introducing it to the Michigan Legislature." With this substitution, the report was adopted as amended.

COMMITTEE REPORTS

17. Annual Summaries of Council Committees

COMMITTEE ON ALCOHOL AND DRUG DEPENDENCE

Herbert A. Raskin, MD, *Chairman*

During the year, the name of the Committee was changed to "Committee on Alcohol and Drug Dependence."

Alcoholism. The Committee continued its liaison with the Alcoholism Program of the Michigan Department of Public Health; reviewed and made recommendations concerning alcoholism legislation; had a meeting with Bruce L. Danto, MD, Chairman of the Detroit Mayor's Skidrow Committee; reviewed continuation of the MSMS thrust on alcoholism education and agreed that committee members should serve as a speaker bureau for component societies and other related groups; will look into the program and activities of the newly formed Michigan Alcohol and Addiction Association; and soon will have a joint meeting with the Committee on Occupational Health to consider a possible statewide meeting on alcoholism in industry for industrial physicians.

Michigan Criminal Code. The Committee made a thorough study of portions of the Code concerned with alcoholism and drug dependence, and recommended that the provisions in the Proposed Revised Michigan Criminal Code pertaining to alcoholism be accepted and supported by MSMS.

The Committee recommended that MSMS support the sections in the Proposed Revised Michigan Criminal Code pertaining to narcotics with the exception that the Committee questions the justification of the severity of the penalties imposed on the possessor of marijuana.

The Council referred the Committee's recommendations to the Committee on Legal Affairs.

Drug Dependence. Copies of all available material and information on the subject of drug dependence have been obtained and studied by the members of the Committee.

The Committee held a meeting with representatives of the House Committee on Narcotics and the Subcommittee on Alcoholism Program (of the Liquor Control Commission). Representative Dale Warner, Chairman of the House Committee on Narcotics, explained the aim and purpose of his Committee was the evaluation of laws governing the equity and adequacy of controls concerned with dangerous drugs and narcotics. In Michigan there is no state allocation of responsibility to meet any of the aspects of drug dependence.

The Committee will continue its liaison with Representative Warner and his Committee.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

A subcommittee has been appointed to investigate the possibility of a physician education seminar in drug dependence; the Committee has offered to serve as a consultative group in relation to drug dependence problems to MSMS members; has recommended to the State Board of Registration in Medicine that its board be expanded to include a group of physicians, qualified in drug dependency, to serve in an advisory capacity to law enforcement agencies in any problem relating to misuse and improper dispensing of drugs by physicians; the Committee will write articles on narcotic drug use and misuse and its relation to physicians for *Michigan Medicine;* and, will review any legislation concerned with narcotics.

The Committee will continue its study of the problem of drug dependency and will keep MSMS members informed.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AWARDS

C. ALLEN PAYNE, MD

During 1967-68 MSMS continued its award program to recognize MSMS members for service to the profession and the public.

MSMS Outstanding Health Service Awards:

The MSMS Council, upon the recommendations of the Committee on Awards, selected 12 Michigan public officials, associations, firms, and foundations to receive recognition for their contributions to medicine and health. The awards were given at the First Annual Michigan Conference on Health Planning on February 24, 1968 to the following:

Clara Elizabeth Fund, Flint
Consumers Power Company, Jackson
Charles E. Forsythe, Lansing
Grand Rapids Press
Secretary of State James M. Hare
Michigan Association of the Professions
Outdoor Advertising Association of Michigan
Senator Robert L. Richardson, Saginaw
Sears-Roebuck Foundation, Chicago
Representative J. Robert Traxler, Bay City
The Upjohn Company, Kalamazoo
WJIM-TV, Lansing

MSMS Distinguished Service Awards:

The MSMS Council, upon the recommendations of the Committee on Awards, selected two MSMS members to receive recognition for their efforts to improve the health and medical care of high school and college athletes. Distinguished Service Awards, presented at the First Annual Michigan Conference on Health Planning, February 24, 1968, were presented to:

James S. Feurig, MD, East Lansing
Gerald A. O'Connor, MD, Ann Arbor

MSMS Awards to National Presidents:

As in the past, MSMS will present its National Presidents Award to MSMS members who are serving as presidents of national medical organizations. The MSMS Council approved the recommendations of the Committee on Awards to present the award to the following during the 1968 MSMS House of Delegates meeting:

H. Marvin Pollard, MD, Ann Arbor
American College of Physicians

Raymond W. Waggoner, MD, Ann Arbor
American Psychiatric Association

Edwin De Jongh, MD, Birmingham
American Academy of Occupational Medicine

Rosser L. Mainwaring, MD, Dearborn
American Society of Clinical Pathologists

John J. Hanlon, MD, Detroit
American Public Health Association

MSMS Flag Awards:

The Council, upon the recommendations of the Committee on Awards, created a new category of awards to recognize Michigan physicians who are serving as presidents of various state-wide organizations. The Council approved awards to 10 Michigan physicians. The awards, given during the First Annual Michigan Conference on Health Planning, February 24, 1968, were presented to the following:

Carl B. Beeman, MD, Grand Rapids
President, Michigan Heart Association

Donald R. Hagge, MD
President, Michigan Archeology Society

John J. Hanlon, MD, Detroit
President, Michigan Public Health Association

William N. Hubbard, Jr., MD, Ann Arbor
President, Michigan Association for Regional Medical Programs

Benjamin Jeffries, MD, Detroit
President, Michigan Epilepsy Center and Association

George D. Maniaci, MD, Gladstone
President, Michigan Association for Retarded Children

G. Frederick Moench, MD, Midland
President, Michigan Society for Better Hearing and Speech

John B. Rowe, MD, Flint
President, Michigan Diabetes Association

G. B. Saltonstall, MD, Charlevoix
President, Michigan Association of the Professions

H. A. Towsley, MD, Ann Arbor
President, Michigan Health Council, and Michigan United Fund

Fifty-Year Service Awards:

The 1968 House of Delegates will recognize physicians who have served 50 years in the practice of medicine. As of September 10 the list of awards included the following — several others may be reported by component medical societies before the actual presentation on September 24:

Calhoun County:
- A. M. Giddings, MD, 104 Kicker Pl., St. Mary's, Ohio 45885
- Welcome B. Lewis, MD, 196 Irving Park Dr., Battle Creek, 49017
- William V. Vandervoort, MD, Route #4, Hastings, 49058

Grand Traverse County:
- Edward F. Sladek, MD, 123 East Front Street, Traverse City, 49684

Ingham County:
- M. S. Hurth, MD, 1717 Jerome Street, Lansing, 48912

Kent County:
- Garnet G. Stonehouse, MD, 408 Medical Arts Bldg., Grand Rapids, 49502

Menominee County:
- Karm C. Kerwell, MD, P.O. Box 17, Stephenson, 49887

Oakland County:
- Sol M. Lewis, MD, 541 West Oakridge, Ferndale, 48220

Saginaw County:
- Lloyd C. Harvie, MD, 330 South Washington Ave., Saginaw, 48607

Wayne County:
- Elden C. Baumgarten, MD, 1062 Lochmoor Blvd., Grosse Pointe Woods, 48236
- Wyman C. C. Cole, Sr., MD, 1116 Leisure Lane, Walnut Creek, Calif. 94597
- Ray S. Dixon, MD, 5001 VanDyke, Detroit, 48213
- Clyde H. Hasley, MD, 2320 North LaSalle Gardens, Detroit, 48206

William E. Hilton, MD, 5013 Harding, Detroit, 48213
Joseph A. Kasper, MD, 1011 Cadieux Road, Grosse Pointe Park, 48230
Fred O. Lepley, MD, 19799 Mack Avenue, Grosse Pointe Woods, 48236
Alton R. Marsh, MD, 15696 Woodland Drive, Dearborn, 48120
Arthur B. Norton, MD, 1077 Fisher Bldg., Detroit, 48202
Robert L. Novy, MD, 858 Fisher Bldg., Detroit, 48202
Harold F. Raynor, MD, 49 Virginia Park, Detroit, 48202
John R. Rieger, MD, 746 Pallister, Detroit, 48202
Isaac S. Schembeck, MD, 1553 Woodward Ave., Detroit, 48226
James M. Stanton, MD, 1001 Mutual Bldg., Detroit, 48226
Milton D. Vokes, MD, 10182 Gratiot Ave., Detroit, 48213
Alfred H. Whittaker, MD, 3 Elmsleigh Lane, Grosse Pointe, 48230

Now in Escondido, California:
T. P. Wickliffe, MD

THE HOUSE, based on the recommendations of the Awards Committee, did present the awards outlined in this report (see Section on Presentations and Awards).

COMMITTEE ON BEAUMONT MEMORIAL

Bradley M. Harris, MD, *Chairman*

Early this year, Mrs. George A. Brotherton, a descendant of Doctor William Beaumont, contacted the committee as to whether or not the Michigan State Medical Society wanted to purchase a silver friendship cup which once belonged to Doctor Beaumont's daughter, Sarah, who in turn gave it to her daughter Lucretia Irwin.

After studying the matter, and consulting with Eugene T. Petersen, Director of the Mackinac Island State Park Commission, the committee decided the friendship cup would be a valuable addition to the Beaumont memorabilia on the Island, because of the historical association with Doctor Beaumont.

The silver friendship cup is currently on display there. Other items in the Beaumont collection are in good condition and well displayed.

The Committee will meet July 20 on Mackinac Island to discuss further matters.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

Richard O. Kraft, MD, *Chairman*

The Committee on Courses on Medical Economics and Ethics met in Ann Arbor on August 28, 1968.

At this meeting the members reviewed the subject material presented during the preceding year to the students at the University of Michigan. A variety of topics were presented including a discussion of osteopathy, problems related to narcotics, military medicine, medicine and religion and the business side of medicine.

The Committee was most concerned about the limited attendance recorded during these sessions by senior students. In previous years and months various methods have been utilized to improve the attendance — including meetings in the evening, less frequent meetings, a change of subject material, a change in technique of presentation, all to no avail.

The Committee approved a recommendation that its chairman investigate alternate times and places in the medical students university experience for these meetings so that more of this valuable material can be presented and appreciated by more students. Included during this forthcoming "trial year" will be presentations to the freshman and sophomore students as well as postgraduate students (residents).

The results of these efforts will be supplied in next year's annual report.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report believing this to be an important work in each of the medical schools in the State, and suggested that thought should be given to publishing in pamphlet form the valuable material contained in the course.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EDUCATION LIAISON

Milton R. Weed, MD, *Chairman*

The Education Liaison Committee, which is one of four standing committees of The MSMS Council, has met twice this past year with two subcommittees also working on special assignments.

The work of the Committee can be divided into five areas:

1. *Ongoing efforts to improve liaison between MSMS and the three medical colleges:* The deans and/or their representatives participated regularly in Committee meetings and studies.

2. *Continuing study of the possibilities of training "physician assistants" in Michigan:* A special subcommittee, with H. J. Meier, MD, as chairman, has conducted an extensive investigation of the 1965 House of Delegates Resolution 20 to consider the development and use of "physician assistants." During 1965-66, 1966-67, and now 1967-68, the special subcommittee has held hearings with representatives of the State Board of Education, the three medical schools, and several medical specialties. The committee has studied materials from the AMA, from Duke University, which has a small physician assistant training program, and from other sources. The committee has concluded that the training of such "assistant physicians" would be feasible in Michigan. The committee has not been able to reach a final decision whether a two-year training program would be possible in community colleges, or whether four years should be required at a university with perhaps a bachelor's degree in medicine given to the graduate. All agreed that upward mobility should be assured so that the person could continue on perhaps at a later date for a regular degree in medicine. At its last meeting, the parent Committee sent a recommendation to The Council "that the Education Liaison Committee be authorized to work with interested component medical societies and physicians and their local institutions of higher education to train such personnel on a pilot basis in order to further explore the feasibility of training physician assistants." The Council approved the Committee request and at least one of the subcommittee members is exploring the subject further with a state university.

Further study of the training program, of the job description, of the many ramifications of licensure, insurance, etc., will be carried on by the parent committee and subcommittees.

3. *Consideration of possible ways to obtain more interns, residents and new physicians for Michigan:* The Education Liaison Committee late in 1966-67 requested permission from The Council to appoint a special task force committee to study changing patterns of selection of internships by graduates of the two Michigan medical schools. The task force, under the chairmanship of Kenneth L. Krabbenhoft, MD, soon expanded its scope to concern itself with the closely related questions about residents and new Michigan physicians. The task force has met with representatives of the University of Michigan Institute for Social Research to develop and conduct a

survey of senior medical students, interns, residents, and new doctors entering practice in Michigan to determine motivating factors, etc. Costs of such a survey has been estimated to range from $5,000 to $7,000. Alternative ways to conduct such a study, or to finance the project, are being considered.

Related to some degree is a medical manpower study underway now in 13 southwestern Michigan counties by the Michigan Health Council with financial assistance from the Michigan Foundation for Medical and Health Education. The MHC executive director has met with the Education Liaison Committee to discuss this regional study.

4. *Consideration of Resolution 46 adopted by the 1967 MSMS House of Delegates:* The Council referred Resolution 46 to the Education Liaison Committee for implementation. The resolved portion read: "that MSMS, in concert with the faculties of the three medical schools and the SAMA chapters establish a preceptorship program throughout the state." The Committee reviewed the reports of a previous subcommittee in 1965-66 and 1966-67 to consider a similar resolution about general practice preceptorships. That subcommittee, after considerable research and study, reported to the 1967 House of Delegates that "the preceptorship approach is only one part of a possible total program" to obtain more GPs in Michigan. The current committee has discussed Resolution 46 with medical school representatives. The importance of qualified preceptors was suggested as one of the key factors in any broad preceptorships for interested medical students. The parent committee referred the matter for detailed study to the task force committee headed by Doctor Krabbenhoft. That committee includes representatives of the three dean's offices. No decision has been reached to date.

5. *Consideration of the Report of the National Advisory Commission on Health Manpower:* The Committee has studied the 53 recommendations made by this national committee. The recommendations and the AMA comments on each appeared in JAMA, February 12, 1968. The Report was discussed by an AMA official at the 1968 MSMS Conference on Health Planning in Detroit.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EMERGENCY AND DISASTER MEDICAL SERVICES

Charles P. Anderson, MD, *Chairman*

During the year, The Council changed the name of the Committee to "Committee on Emergency and Disaster Medical Services." Therefore, the scope of the Committee has been enlarged to include emergency medical services to persons injured in accidents and to other injured and ill persons who go to hospital emergency rooms.

The Committee urges all component medical societies, with the help and cooperation of the local health department, to take leadership in developing an emergency medical care plan.

Also, it is suggested that in times of disaster, civil disturbance, and other emergencies in areas located within the county society, a representative of the county society or societies involved, contact the physicians in the disaster or emergency area to offer the help of the county society and its members. This call should be made before a request for help comes from the disaster or emergency area.

The Committee feels that H.B. 3946, licensing of ambulance attendants, now a Michigan law, will contribute greatly to the safety of patients being transported to hospitals. The Committee urges all members to give their full support to the implementation of this law and to cooperate in any way possible with the training of the personnel involved.

The Committee will endeavor to keep the membership informed via the publication of articles, news notes, etc., in *Michigan Medicine* and other MSMS publications.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EYE CARE

Robert T. Blackhurst, MD, *Chairman*

The Committee continued its liaison, in an advisory capacity, with the Michigan Department of Public Health, Bureau of Maternal and Child Health and with the Michigan Department of Social Services, Services for the Blind Division.

A postal card survey, seeking information on blind-deaf children in Michigan, was sent to all physicians and osteopaths in Michigan. This information will help to bring educational aid to these blind-deaf children and to their families, through the services of the Michigan School for the Blind.

A subcommittee is working on revisions to the State's Blind aid form; and reports were presented and discussions held on the school and preschool vision screening programs, color testing, aid to children under the Medical Eye Care Program, the identification of blind and deaf-blind infants, and the follow-up of visual referrals. The Flash Card Vision Test was demonstrated for the Committee and it was recommended that the MDPH proceed with this testing.

A report of attempts being made to identify dyslexic children and further educate them was discussed by the Committee. The pilot project in the Lansing school area is attempting to identify those children with essential dyslexia, apart from all other children. This subject will be reviewed at future meetings of the committee.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON INTERNATIONAL HEALTH

Hira E. Branch, MD, *Chairman*

One of the main efforts of the International Health Committee during the past year was to publicize the need for more medical aid to the civilian population of South Vietnam.

Doctors who had been to South Vietnam appeared on radio and television shows, urging that the United States government make a larger commitment of medical aid to South Vietnamese civilians and informing the public of the American Medical Association's Volunteer Physicians for Vietnam program.

Alfred Swanson, MD, of Grand Rapids appeared before several government groups urging an increase of medical aid to South Vietnam.

Various newspapers around the state carried feature articles and editorials on this subject. Throughout the year *Michigan Medicine* carried news articles, pictures, and editorials urging physicians to consider giving their time for work in South Vietnam. In addition, a long feature article, detailing the experience of Michigan physicians in South Vietnam, along with a special cover appeared in the February, 1968 issue of this publication.

During the period July 1, 1965 to June 30, 1968, eighteen Michigan doctors served in the Volunteer Physicians for Vietnam program.

Throughout the year, the Committee has furnished information to interested physicians about the various organizations which sponsor medical work overseas.

At present the Committee is studying the possibility of holding a one-day workshop, in cooperation with the MSU Extension Service, for physicians and lay groups on international problems of food and population.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

Harvey C. Hansen, MD, *Chairman*

The Chairman wrote to the Wayne County Medical Society suggesting that, because a joint code of understanding failed to materialize at the State level, liaison between WCMS and the Metropolitan Detroit Pharmaceutical Association might be advisable and mutually advantageous.

Resolution 7 of the 1966 House of Delegates and Resolution 10 of the 1967 House of Delegates involving Rule 16 of the Michigan Board of Pharmacy were reviewed. Further study and analysis is required before recommendations can be made. Also discussed was Resolution 50 of the 1966 House of Delegates concerned with improving the method of uniform drug identification, but no action was taken.

Discussed were the use of charcoal in Poison Antidote Kits, ethics of pre-printed prescription blanks, MSPA attempts to gain representation on Board of Michigan Association for Regional Medical Programs, drug control, prevention of refilling same prescriptions by several pharmacies, nurses' liabilities and responsibilities when telephoning orders, and the need for liaison to resolve mutual problems when they arise.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH PODIATRY

Wm. H. Blodgett, MD, *Chairman*

Pursuant to Council direction, the Liaison Committee with the Michigan Podiatry (Chiropody) Association has been engaged during the past year in dialog with leading elected officials of that organization, for the purpose of improving the understanding of physicians of the training, practice and goals of podiatry and the understanding of podiatrists of the policies of medicine concerning paramedical practice privileges in hospitals.

This constitutes an interim report, inasmuch as extensive study is going forward, on the status of podiatry around the United Sates both educationally and with regard to state laws. Considerable material has also been received from the American Medical Association and from the Joint Commission on Accreditation of Hospitals which will be carefully evaluated. Following this additional meetings with Michigan Podiatry officials will be required before a final report can be developed.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended acceptance as an interim report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH RESIDENTS, INTERNS, AND SENIOR MEDICAL STUDENTS

Norman D. Henderson, MD, *Chairman*

The Committee, after work with Merck, Sharp and Dohme, has finished plans for an educational conference on Office Management for residents, interns and senior medical students on the afternoon of September 26 at the Sheraton-Cadillac Hotel in Detroit, during the MSMS Annual Session.

Various topics for the conference were considered, and the Committee decided that the program should focus on basic principles of office management. Members of the Committee felt that the conference would be very beneficial to the young physician who is setting up practice so that his office can be both efficient and flexible enough to grow with his practice.

Conference topics were narrowed to four: a) opening an office; b) selecting personnel; c) billing system; d) evaluating partnership prospects.

The Committee is grateful to Merck, Sharp and Dohme for support of this conference and feels that this unique event will not only be of educational benefit to the young or prospective physician but will serve as an effective way of introducing him to the activities of the Michigan State Medical Society.

The Council has delegated to this Committee the authority for implementation of Resolution 54 of the 1967 House of Delegates, which deals with MSMS liaison with students of the health care professions. This matter is being studied and recommendations shall be made as soon as the Committee completes its work.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

Orlen J. Johnson, MD, *Chairman*

Revision of Statement of Principles for Lawyers and Physicians. This Committee and the State Bar Medico-Legal Committee have recommended revision of the House of Delegates, which deals with MSMS Liaison present agreement between MSMS and the State Bar. These revisions place the responsibility on the attorney to pay the physician a reasonable fee for services rendered in cases where the physician aided in preparing a case, but did not have the opportunity to testify. These changes have been approved by The Council and are now being considered by the State Bar Commissioners.

Resolution 14, 1967 House of Delegates. This resolution, concerning the feasibility of establishing a commission to study the problem of increasing malpractice suits against physicians, has been favorably considered by both committees. Representatives from both professions will soon be appointed so that this important study can be underway.

Resolution 58, 1967 House of Delegates. This resolution, aimed at clarifying Michigan law to safeguard the privileged character of medical records, is under active study by both committees. A report will be made to The Council as soon as this study is completed.

Better Communication Between the Two Professions. A plan to improve communication between the two professions by establishing liaison representatives on a geographic district basis is being developed. A full report will be made to The Council as soon as this work is completed.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON WITH STATE BOARD OF REGISTRATION IN MEDICINE

K. H. Johnson, MD, *Chairman*

The Committee met with the members of the State Board and representatives of the Investigations Division, Department of Licensing and Regulation. Items discussed were training of investigators, limitations of Medical Practice Act, responsibilities of office personnel performing delegated services and the use and abuse of narcotics.

MSMS has asked the State Board to annually publish a list of those licensed to practice in Michigan by county with a copy to each county clerk.

MSMS also urged the State Board to study and implement, if possible, the following recommendation:

> "The State Board be expanded to include a group of physicians, qualified in drug dependency, to serve in an advisory capacity to law enforcement agencies in any kind of problem that would have to do with misuse and improper dispensing of drugs by physicians."

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE EXECUTIVE OFFICE

Kenneth H. Johnson, MD, *Chairman*

One of the most vital correlated activities of the "governmental relations" section of the MSMS Headquarters office is the maintenance of close and effective liaison with the Office of the Governor of Michigan, including not only the Chief Executive himself but also his chief staff aides concerned with legal, agency and program matters. Policies of MSMS are enunciated to the Executive branch of Michigan State Government through the activities of this liaison committee, which also assists upon request with appointments to councils and advisory bodies. Appropriate contacts are also made with the Lieutenant Governor and his staff.

It is more the rule than the exception that the Executive Office will consult the MSMS Liaison Committee on such matters of great importance to medicine as formation of the State Health Facilities Council, Comprehensive Health Planning Advisory Committee, and similar bodies. As an example of the importance of matters discussed by this Committee and the Executive Office, the study of a possible merger of the Public Health and Social Services Departments is cited. The Committee acts only upon directive of The Council.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS

James S. Feurig, MD, *Chairman*

The Committee's major activity this year was the presentation of the Third Annual Michigan Conference on the Medical Aspects of High School Sports at Detroit, May 8, 1968. The Committee organized the fine program and secured the cosponsorship of the University Center for Adult Education (a cooperative adult-education project of Wayne State University, the University of Michigan and Eastern Michigan University) to obtain use of the Rackham Center in Detroit.

One hundred team physicians, coaches, trainers and high school principals participated in the program. Speakers included team physicians for the Notre Dame Irish and the Ohio State Buckeyes, and an official from the dental service division of the Michigan Department of Public Health.

The Committee, with the approval of The Council, is now actively urging component medical societies to help high schools in their area to obtain doctors of medicine to serve as team physicians.

Three committee members spoke at the annual meeting of the Michigan Association of physical education.

The Committee cooperated with the Committee on Child Welfare in its development of a position statement about high school wrestling weights for the State Departments of Education and Public Health.

The 1968 MSMS Awards Luncheon in Detroit February 24 included "Outstanding Health Service Awards" to Charles Forsythe, executive director of the Michigan High School Athletic Association, and to two members of the Committee, Chairman James S. Feurig, MD, East Lansing, and Gerald A. O'Connor, MD, Ann Arbor.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND RELIGION

Winslow G. Fox, MD, *Chairman*

The moral and ethical issues facing physicians today were discussed at MSMS headquarters by 30 chairmen of county medical society medicine and religion committees and other invited guests, in a day-long workshop.

The Reverend Doctor Paul B. McCleave, Director of the AMA Department of Medicine and Religion participated in the Workshop. Luncheon speaker was LeRoy Augenstein, Ph.D. – his topic: "Who Shall Decide?"

The Committee on Medicine and Religiou co-sponsored with Alma College a physician-clergy workshop on May 2, 1968. Keynote speaker was Reverend Robert E. Reeves, Jr., Chaplain of Columbia Presbyterian Medical Center, New York City.

During the past year over 35 county medical societies participated in medicine and religious activities. The Committee hopes that every county society will name a chairman and activate a committee in 1969. This Committee's purpose is to develop a program to create a stimulating climate for communication between physicians and clergymen, leading to more effective care and treatment of the patient.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MICHIGAN MEDICAL HISTORY

John R. G. Gosling, MD, *Chairman*

During the past year the Committee has continued its interest in Michigan's medical history in the following ways:

The Committee recommended (and The Council approved the recommendation) that a repository be determined for objects, literature, photographs, etc., of an historical nature. Accordingly, space has been made available at MSMS Headquarters for such a repository.

Through Alfred H. Whittaker, MD, the Committee has contacted the Michigan Historical Society and proposed that it establish a medical history branch. Work on this project is continuing.

The Committee has also investigated the possibility of distributing the Stapleton book on medical history during the Wayne State University Medical School's centennial celebration and at various medical meetings. Work on this project is also continuing.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON NURSING

Robert L. Tupper, MD, *Chairman*

During the past year the Committee has been concerned with various questions of nurse practice. After much deliberation the Committee decided that its role in answering many of these questions is to serve as a clearinghouse for the questions, referring them to the appropriate medical and nursing specialty groups for their recommendations. The Committee does, however, recommend that guidelines for nursing practice be established.

The Committee has also been interested in various legislative issues, specifically the proposed rules and regulations to the Nurse Practice Act of 1967.

In October 1967 the Committee Chairman attended the AMA-sponsored Conference on Nursing in Chicago. One of the charges there was for each state Committee to attempt to develop dialogues similar to the three previous ones conducted nationally between physicians and nurses. Partially as a result of this and partially by independent impetus from the liaison group from the Michigan Nurses Association, a significant effort to this end was developed.

Accordingly, the major work of the Committee during the past year has been to plan and sponsor an MD-RN dialogue-type conference, September 4-5, 1968, at the MEA Conference Center, St. Mary's Lake. Outstanding speakers should fulfill the three main objectives of the Conference: 1) to serve as a pilot venture for future local and state level conferences to improve physician-nurse working relationships; 2) to improve the physician-nurse working relationships and understanding in actual practice; and 3) to improve patient care as a result of better cooperation between physicians and nurses. The Committee is grateful to MSMS and the MNA for their financial support of the Conference.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON REHABILITATION

Richard W. Pomeroy, MD, *Chairman*

1967 House of Delegates Referrals. The Committee considered Resolution 22 entitled "Study of Adequacy of Training of Certain Paramedical Personnel."

During the year, the Committee studied the "Proposed Guidelines for Physician Therapy Aide Training" as printed and approved by the American Physical Therapy Association. The "Guidelines" are essentially an outline of subject matter which could be included in an aide training program. The "Proposed Program for Physical Therapy Aide Training," a sample of the way that an aide training program might be organized, also was reviewed by the Committee. Guidelines and program for the training of assistants have not as yet been approved by the APTA.

The Committee does not see how it can make the study as indicated in the resolution, but feels it is in a good position to review any new programs for the teaching and training of paramedical personnel in the State and will keep The Council informed.

In reviewing Resolution 23, "Recognition of the Board of Registration of Physical Therapists," the Committee informed The Council that there is only one body of registered physical therapists, with no other level of physical therapists being recognized at this time. The Michigan law definitely sets forth the qualifications of a physical therapist.

The Committee sent an explanatory letter and a copy of the Michigan law to the secretaries of Michigan's component societies on August 31, 1967.

The recommendation contained in the *Annual Report of the Liaison Committee with the Michigan Crippled Children Commission and Resolution 25,* concerned with the care of handicapped children, were reviewed by the Committee.

The Committee will cooperate in all ways possible with the Committee for the Care of the Handicapped Child of the American Academy of Orthopaedic Surgeons and will maintain liaison with other organizations, agencies and departments involved in the care of handicapped children in Michigan.

Rehabilitation Nursing. The Committee asked The Council to make known to the Michigan Association for Regional Medical Programs its concern that there is a real need for nurses to be trained in the rehabilitation aspects of heart disease, cancer and stroke, and to urge MARMP to set up a program in the immediate future to insure an adequate number of trained rehabilitation nurses to care for patients suffering from heart disease, cancer, stroke and related diseases.

MARMP replied that a Rehabilitation Nursing Program was being developed at Wayne State University and University of Michigan and that other programs were under consideration, and that the recommendation would be shared with the appropriate corporation committees, the three universities and the Michigan Department of Public Health.

Rehabilitation Nursing Careers. The Committee is cooperating with the Michigan Health Council in setting up an exhibit for the Career Mobile and working on the possibility of moving beyond the exhibit and attempting to make some personal contacts with the students in the schools. The Committee feels it important to get the personal involvement of students interested in rehabilitation nursing, after the initial exposure to the exhibit.

Visit to Traverse City. The Committee visited the rehabilitation facilities at Munson Hospital in Traverse City and plans to visit other such facilities throughout the State.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended acceptance of the report.

THE HOUSE adopted the report of the Reference Committee.

RELATIVE VALUE STUDY COMMITTEE

Ben R. VanZwalenburg, MD, *Chairman*

The Committee, by a meeting on April 6 and by intracommittee correspondence has carried on its assigned task of studying the Michigan RVS.

The finalized AMA current Procedural Terminology (CPT) has not been published. This precludes any attempt to resolve the differences between the CPT and the Michigan RVS. We expect that the CPT will eventually be adopted nation-wide and that the Michigan RVS should be brought into line with the CPT nomenclature and numbering system.

The need for continuing the Michigan RVS was discussed. It is obvious that the "variable fee" type of payment by third parties will more accurately reflect current charges and their variations by location and by specialty than does an RVS. The Committee, however, feels that the Michigan RVS should be continued as it is a valuable reference for physicians and third parties.

The continuing necessity for annual revision of the Michigan RVS is indicated because fee patterns are constantly changing in response to developments in medical science and practice.

The Committee recommends approval of the *1965 Michigan Relative Value Study,* (revised 1968) to mirror current relative values. The 1968 revisions include minor changes in Neurosurgery, major changes in Anesthesiology and changes in Radiology, Radiotherapy-Radionuclides. (It is expected that the changes in Radiology nomenclature will be largely followed in the new CPT).

Errors in last year's RVS were corrected by omission of procedure 9606 and correction of procedures 9359 and 9363.

The Committee expresses its thanks to the representatives of the Michigan Association of Neurological Surgeons, the Michigan Society of Anesthesiology and the Detroit Roentgen Ray Society for their assistance. The Committee also expresses appreciation to Richard Campau and his office for carrying out the involved staff duties inherent in preparation of this year's revisions.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the RVS, revised 1968.

THE HOUSE adopted the report of the Reference Committee.

18. Annual Summaries of Standing Committees

ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

GLENN E. MILLARD, MD, *Chairman*

There have been no formal meetings of the Committee during the past year, although many of the advisors have attended meetings of the Medical Assistants Society, and the advisors have been asked for their counsel and advice.

The Committee has been very much interested in the education and certification programs of MSMAS and has encouraged the expansion of these programs. The MSMAS Education Committee is constantly striving to increase the number of formal training centers in Michigan and to insure the excellence of the training they provide. In addition, MSMAS has sponsored two educational seminars for its members as well as an officers' training conference during this past year. Eight MSMAS members are now Certified Medical Assistants, indicating that they have passed examinations requiring great competency in clinical and administrative fields. The Committee encourages MSMAS members to prepare for and take the certification exams.

MSMAS has undertaken several public relations projects this year. The AMA publication "Winning Ways with Patients" has been distributed to over seven thousand physicians' offices throughout Michigan. MSMAS officers and the Committee Chairman have written articles published in *Michigan Medicine*, and special medical assistants meetings and programs have been publicized in the news media.

Despite a growing membership in MSMAS, the Advisory Committee continues to be concerned about the number of members. The Committee urges MSMS members to encourage their medical assistants to join MSMAS.

Further information about the activities of MSMAS during the year are given in the President's report to the House of Delegates and her written report in the Delegates' Notebook.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

EDWARD H. RODDA, MD, *Chairman*

Since no problems of policy relative to the Auxiliary arose during the past year, it was not necessary to call a formal meeting of the Advisory Committee. However, all members of the Committee were readily available for advice and counsel.

The Advisory Committee urges all MSMS members to encourage their wives to join the Auxiliary and help advance its work. Although membership has increased during the past year, the Advisory Committee would like to see the potential membership realized.

The Auxiliary has undertaken and completed many valuable projects during this year, many of which are reflected in the President's report to the House of Delegates and in her written report in the Delegates' Notebook.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AGING

A. HAZEN PRICE, MD, *Chairman*

The Committee on Aging has held two meetings with excellent attendance of its membership. Of major committee interest were (1) aspects of nursing home care, (2) the progress of MARMP, and (3) the extent of inclusion of concepts of preventive medicine in the curriculum of medical schools. An area conference on rehabilitation and long term care of elderly patients was held at the Saginaw County Hospital, with the Committee on Aging as cosponsor.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended that this very important committee offer direction to the members of MSMS and that it encourage further liaison with the AMA Committee on Aging.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON BLOOD BANKS

LAWRENCE W. GARDNER, MD, *Chairman*

Having secured The Council's support on May 9, 1967 — "approved study by the Committee on Blood Banks regarding the possible establishment of a central (viral hepatitis) registry, the study to include methods of financing and legal responsibilities of providing information concerning donors," probing actions have been made to the Red Cross and Michigan Department of Health. Both organizations have expressed sincere interest in this endeavor and are in the process of formulating specific recommendations to our Committee.

Relative to the Red Cross: American Red Cross at the national level does not object to such a registry and have made computer space available to the Southeastern Michigan Chapter for this purpose on a community wide basis, if the community desires to participate. However, a definite proposal has not been rendered.

Relative to the Michigan Department of Health: An application for a contract has been sent to the National Heart Institute for financial support to determine the feasibility of a serum hepatitis registry. This study would include actual trials of a proposed system. The type of system, mode of operation, method of financing, effectiveness, etc., are points requiring considerable investigation.

These organizations and our Committee feel that a statewide system of reporting to blood banks those persons having had hepatitis or having been implicated in a transfusion causing hepatitis will be valuable. At the present time, such a system for controlling viral hepatitis has not been formulated in any state. We trust the House of Delegates appreciates the tremendous complications of this endeavor.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CANCER

Max E. Dodds, MD, *Chairman*

The Committee discussed how the MSMS and its members could participate in an educational program on smoking and health. Discussions were held with a representative of the Michigan Council on Smoking and Health and the MSMS Public Relations Committee, and a subcommittee was appointed to meet with other scientific committees to subsequently present recommendations to The Council for such a program.

The Committee feels that MSMS should become meaningfully involved in and influence projects developed by universities and others in connection with the programs of the Michigan Association for Regional Medical Programs. The Committee recommended to this organization that it consider at pilot program of two-way radio conference programs and the establishment of a training course for teaching of uniform tumor registry procedures for local hospital personnel. MARMP replied that the recommendations would be shared with the appropriate corporation committees and with the three universities along with the Michigan Department of Public Health and the Michigan Cancer Foundation.

The Committee expressed its view that all hospitals in Michigan should have approved cancer programs with trained personnel. A survey of the status of cancer registry techniques in Michigan will be made by the Committee.

In addition, the Committee will look into the Muskegon video educational to see if there is a way this type of program can be extended to cancer education in Michigan, through the cooperation and help of the Committee.

The Committee feels that, although health and cancer quackery exists in Michigan, the problem does not seem to be too great.

Two members of the Committee continue to serve as representatives to the Michigan Cancer Coordinating Committee with routine reports to The Council. The MCCC continues to coordinate cancer efforts in Michigan and supplies cancer speakers for meetings of physicians, dentists, and osteopaths.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, was impressed with the Committee's activities and recommended acceptance of the report with minor editorial changes.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CARDIAC DISEASE CONTROL

Sidney E. Chapin, MD, *Chairman*

Rheumatic Fever. Cooperation has continued with the Michigan Heart Association's Rheumatic Fever Committee and the Committee has helped with the statewide rheumatic fever conferences. Discussions were held with the MHA rheumatic fever coordinator. The Committee will continue to evaluate 1. the value and use of throat cultures; 2. the need for community programs; 3. the "injudicious" use of antibiotics; 4. problems of people with fixed valvular heart disease; 5. the unavailability of adequate laboratory service in some communities; 6. the possibility of circulating laboratory service, with the help of local health departments; and, 7. the use of "do-it-yourself" throat culture kits.

The Committee has offered its help to the Michigan Department of Public Health in its current study of bicillin program.

Nutrition Survey. The MHA Nutrition Survey has resulted in 1,914 responses. When the coding is completed and the report written, the Committee will review the results.

Michigan Association for Regional Medical Programs. The Committee met with A. E. Heustis, MD, Executive Director of MARMP, and recommended that, because The Council of MSMS can, and does, disseminate information to individual physicians, it launch a program to acquaint the "grass roots" physicians, statewide with the aims and program of MARMP.

The Council approved this recommendation and in addition, requested Doctor Heustis to prepare an article for publication in *Michigan Medicine* in August or September, 1968.

Screening Program. The Committee reviewed the action taken by the 1967 House of Delegates regarding screening programs.

Guide for the Registered Nurses in a Cardiac Care Unit. The Guide has been reviewed and approved by the Committee.

Liaison. The Committee will continue its liaison with MHA and other persons and groups concerned with cardiac disease control.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CHILD WELFARE

John M. Dorsey, Jr., MD, *Chairman*

The minutes of the Committee's meeting will not be considered by The Council until the time of the 1968 Annual Session.

The Committee is recommending that The Council request the Michigan Department of Social Services to consider changing its rules regarding summer camp physician examination and immunization requirements to fit in with the Committee's recommendation of May, 1967: "(1) That if a physical examination has been given the child within a period of six months; (2) That if the child's immunizations are current; and (3) That if a child has not been exposed to recent communicable diseases, such examination of six months duration be considered adequate to cover the requirement of a physical examination prior to entering summer camp. This examination is not to exclude the health inspection given on the day the child enters the camp."

Due to increasing requirements and needs for better and closer liaison between physicians and schools and school board personnel, the Committee is recommending that The Council recommend to component societies that attempts be made to develop better local school health liaison; also, that The Council make known to the Michigan State Board of Education this interest on the part of physicians in Michigan with the suggestion that the State Board in turn recommend to all local school boards that a contact be made with the local county medical society, requesting the appointment of medical consultant(s) to the local school board.

A committee has been appointed to work with interested personnel from medicine, education and related fields, to study the problems and experiences in the Midland area with the use of the Wetzel screening system and to report back to the Committee. The Wetzel screening system in the Midland area in 1967 found that the average growth failure was 16 per 1,000 children examined.

The Committee has recommended that The Council take special note of the pre-pilot project being done in the Lansing schools to ascertain the number of dyslexia children and what can be done to help them. At the proper time, the Committee will publish in *Michigan Medicine* information regarding the dyslexia project and resulting recommendations.

Also considered by the Committee was Resolution 14 of the 1965 House of Delegates and the referral of the Resolution to it by the Liaison Committee with the Michigan State Pharmaceutical Association. Objection had been heard about the continuing use of charcoal as contained in the Poison Antidote Kit despite the fact that articles had been published recommending its use in certain instances of accidental poisoning.

The Committee is recommending to The Council that it approve the Committee's statement recommending the use of the Poison Antidote Kit, as sponsored by the Michigan State Pharmaceutical Association. In order to provide uniformity across the country, and to avoid conflict with the recommendations of the American Association of Poison Control Centers, the Committee feels that the charcoal contents of the kit, when used in accordance with proper instructions, constitute no extra hazard.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DIABETES

William M. LeFevre, MD, *Chairman*

Since no matters were brought to the Committee during the past year, no meetings were held.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with the suggestion that the Committee explore the feasibility of closer liaison with the Medical Advisory Committee of the Michigan Diabetic Association.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON GOVERNMENTAL MEDICAL CARE PROGRAMS

Paul T. Lahti, MD, *Chairman*

The Committee was supplied with pertinent information by representatives of the Michigan Association for Regional Medical Programs, Michigan Department of Public Health and the Michigan Office of Economic Opportunity so that now the Committee can be of greater assistance in recommending appropriate MSMS coordination and cooperation. The Council adopted a recommendation that component medical society members be more active in every health planning organization concerned with medical care and its distribution. A list of organizations representing or involved with hospitals currently working in a socio-economic field was prepared and distributed to all officers of component medical societies.

The Committee reviewed the 1967 amendments to the Social Security Act and is studying the Report of the National Advisory Commission on Health Manpower.

As a result of the Chairman's attendance at the National Conference on Health Care, the Committee was authorized to and did communicate with all federal/state agencies in Michigan involved in health care for the poor to offer to provide medical advice and consultative services. A recommendation to hold a statewide conference on health care for the poor as a part of the next MSMS Scientific Session was referred to the Ad Hoc Committee to Study the Medical Problems of the Disadvantaged in Cities.

The Committee continued its concern for physicians' reimbursement by all governmental agencies. The Council accepted a recommendation that "In the future, payments from all governmental agencies be on the same basis (the usual, customary and reasonable fee) as Title 18B-Medicare and that this recommendation be forwarded to all county medical societies for use in negotiating with local governmental agencies."

Attention was also devoted to matters related to extended care facilities, such as death certificates, stocking of emergency drugs, reports of radiologists' and physicians' visits, and length of stay.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended acceptance of the report commending the Committee for its diligent efforts.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HIGHWAY INJURY

Paul W. Gikas, MD, *Chairman*

The Committee succeeded in securing approval to distribute Medi-Labels to responsible lay organizations as well as to physicians.

By request of the Secretary of State, the Committee was uniquely privileged to review the manner in which the Department evaluates medical statements as they relate to driver licensing, as well as the procedures used, to initiate a request for medical opinions. Informal meetings and liaison preceded the on-the-spot review and a critique was transmitted to the Department making appropriate suggestions for improved methodology.

The Committee continued its quest to upgrade the emergency medical transportation system. Discussions were held with appropriate state legislators and Department personnel offering strong support for the establishment of minimum standards for ambulances, ambulance drivers-attendants. Members testified before three special committee hearings and maintained continuous liaison.

The Committee was invited to recommend nominees for Executive appointments and handled a number of requests for information and assistance.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON IODIZED SALT

Brock E. Brush, MD, *Chairman*

During the past year, several attempts have been made to select a meeting date convenient to most of the members of the Committee and to the three representatives from The Council. A meeting was scheduled with five Committee members and two of the Council's representatives indicating they would be present. Those present felt it important to discuss the future program and purposes of the Committee and to make recommendations that might be considered by the 1968 House of Delegates.

The Committee recommended to The Council that the Michigan State Medical Society renew its efforts and take active leadership with material interest in the support of the education of the public and of the physicians in the State of Michigan to stress the need for using iodized salt to prevent endemic goiter, which, according to the studies of William H. Beierwaltes, MD, and his associates, of Ann Arbor, is a continuing and rising problem among the citizens of the State of Michigan.

At its meeting in June, The Council discussed the possibilities of: 1. including goiter under the Public Health Committee, and 2. the possibilities of MSMS legislative efforts to make iodized salt mandatory under state law. The Council agreed that both possible approaches should be explored further with the Committees on Public Health and on Legal Affairs.

Therefore, the future of the Committee on iodized salt rests with the recommendations resulting from a future joint meeting of the Committee on Iodized Salt, the Committee on Public Health, and the Committee on Legal Affairs. Our Committee would like to move ahead on these problems and do a more effective job. We are not satisfied with our progress of the past few years.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended approval of the report and encouraged favorable joint action by the Committees on Public Health and Legal

Affairs in the proposal to secure legislative action to insure continued success in this public health measure.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON LEGAL AFFAIRS

Otto K. Engelke, MD, *Chairman*

An extremely arduous year of legislative activity was completed on June 26, 1968 with the adjournment of the Michigan State Legislature. During six months of intensive activity the lawmakers in Lansing considered hundreds of health-related proposals, some of them of great significance to all practicing physicians. At the close of the session not one new law had been added to the Michigan Statutes which had been vigorously opposed by MSMS; on the other hand, the Society had strongly supported passage of fully as many bills as it had felt it necessary to oppose or seek to amend, and a large number of MSMS-endorsed bills were adopted to the benefit of the profession and the people of Michigan.

The Legal Affairs Committee commences to prepare for a legislative session immediately following each meeting of the House of Delegates. It has met on more than one occasion before the Legislature gathers in the State Capitol and it meets again several times during the session proper. In this past year activities have been thoroughly reported to the total MSMS membership through a half-dozen "Medigrams," special letters when required in emergencies, and many pages of articles in the centerfold of *Michigan Medicine*. A complete recapitulation of bills of interest was mailed to all members on June 4, at which time a new service was instituted making available to any physician who requested them copies of any newly enacted laws of particular interest to him.

It must be strongly emphasized that the success of MSMS' legislative effort is always due in large measure to the splendid response of the profession when it is called upon to speak to individual legislators about important proposals. MSMS members, during 1968, have been particularly alert and cooperative, and the State Legislature by and large has been courteously receptive to MSMS views. Much hard work must be done by those who are "on the firing line" every day, and many individual physicians have given generously of their time and expertise to come to Lansing to actually testify before committees. The fact, however, that increasingly physicians are taking an active interest in government, getting to know their own lawmakers, and expressing themselves regularly has strengthened a key ingredient in our legislative activity. The Committee wishes it could personally thank every member who has assisted during this past year.

Finally, the Committee would point out that a new State Legislature will be elected a little over a month after the 1968 House of Delegates meeting. Being so intimately associated with the importance of volume of legislative activity, the Committee would most strongly urge every physician, as an individual citizen, to evaluate the political candidates in his community and support, in any way possible, those whom he considers best qualified to make the laws of our State.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the report congratulating the Committee for an excellent job.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MATERNAL HEALTH

James E. Harryman, MD, *Chairman*

The Central Maternal Mortality Review Subcommittee has continued its review of maternal deaths in Michigan and has been greatly aided by the large percentage of autopsies performed.

The Perinatal Morbidity and Mortality Subcommittee has distributed three Perinatal Newsletters during the past year, and has provided information and help to Michigan hospitals wishing to participate in the Michigan Perinatal Mortality Study.

The Lay Education Subcommittee served as the motivating force in the successful adoption of legislation to permit the teaching of family life and sex education in Michigan's schools. The Committee will continue to serve in an advisory capacity to the Michigan Department of Education, and to other groups involved in setting up the curriculum for the teaching of family life and sex education. In addition, the Committee plans a Family Life Education Workshop for representatives of component societies next October.

The Medical Liaison Committee continues its publication of Desk Reference Cards and has received the approval of The Council to reprint all 10 cards in a future issue of *Michigan Medicine* and to print future cards in this manner.

The Maternal Mortality Tissue Registry Subcommittee hopes that it will be possible to have a complete report assembled by the end of 1968. The report will include study sets of significant pathology with Kodachrome slides and text. The year 1968 marks the Tenth Anniversary of the Registry.

The Annual Maternal Health Conference Subcommittee held another very successful Maternal Health Conference in Flint in March. The Annual Report of The Council contains a report on this meeting. The Committee is grateful to the Clara Elizabeth Fund of Flint for its continued interest and tangible help in co-sponsoring the Flint Maternal Health Conferences.

The Committee continues its cooperation with the Michigan Department of Public Health, Bureau of Maternal and Child Health, in efforts toward better utilization of obstetrical hospital beds.

Other matters discussed by the Committee during the past year: Michigan perinatal and infant mortalities; prematures and what kills them; RH immunoglobulin; training in obstetrical care and delivery for all physicians accepting patients for such care; the bringing together of physicians, hospital board members and hospital administration to discuss the combined responsibility of obstetrical care; the need for more hospital perinatal study officers and review committees; the training of more nurses for obstetrical care; and Michigan's abortion laws and other legislation of concern to the Committee.

The Committee expressed appreciation to William W. Jack, MD, for his good work as Chairman of the Committee for many years, and sadness and great loss in the death of Arthur C. Rutzen, MD, a long-time member of the Committee and the newly appointed Chairman at the time of his death.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended approval of the report with highest commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

Dale L. Kessler, MD, *Chairman*

Long Range Planning Project. The following position papers have been received and published in *Michigan Medicine:*

1. "The Future of Health Insurance, Prepayment and Medicine — A View of 1985," by Charles P. Hall, Jr., Ph.D.
2. "The Outlook for Group Practice — Prepayment Direct Service Plans During the Next 20 Years," by Caldwell B. Esselstyn, MD.

3. "The Medical Profession and the Public: An Examination of Interrelationships," by Odin W. Anderson, Ph.D.

Additional papers have been received or are under contract and will be published within the next several months. They are:

1. "The Future of Private Practice: Salvation at the Grassroots," by Lewis A. Miller
2. "Medical Facilities and Medical Practice 1985," by Ray E. Brown.
3. "The Influence of Government Fiscal Agents on the Future Practice of Medicine," by Thomas B. Fitzpatrick.

After all the papers have been published in *Michigan Medicine*, reprints will be sent to each state medical society. It is hoped that this will result in the development of new approaches and programs by organized medicine to meet the challenges that medicine will face. Also, the Committee will conduct workshops around the state to focus the attention of component medical societies on the future.

The Committee is pleased to report that Charles Hall's paper on "The Future of Health Insurance and Prepayment" was selected by a jury representing the American Medical Association, the American Medical Writers Association and the National Association of Blue Shield Plans as the most scholarly contribution to the literature of medical economics for the year ending June 30, 1967. Doctor Hall was presented the Norman A. Welch MD Award by the N.A.B.S.P. for his achievement.

Survey of Fees in Wayne County. Upon the recommendation of the Committee, The Council approved a request from the Wayne County Medical Society that the Committee conduct a survey of fees by specialty and type of practice in Wayne County. This survey is underway. The results should be of significant value to physicians, not only in Wayne County, but throughout Michigan.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND OSTEOPATHY

John J. Coury, MD, *Chairman*

This Committee again had a busy year in its attempts to formulate policies that would resolve the problem of Medicine and Osteopathy.

Our major efforts concerned 1) the development of a proposed single medical practice act for Michigan and 2) obtaining changes in the policies of AMA that would permit qualified osteopaths to participate in AMA-approved internship and residency programs.

The Committee worked closely with the MSMS Committee on Legal Affairs and MSMS Legal Counsel in drafting a new medical practice act that would place both MDs and DOs under one licensing board. The details will be presented to the House of Delegates in a separate report.

Resolution 60 (Acceptance of Osteopaths as Residents and Interns) of the 1967 MSMS House of Delegates was presented at the June meeting of the AMA. Although the resolution was not adopted, it will be considered by the AMA Council on Medical Education, which is studying this entire matter.

This concept is condemned by the American Osteopathic Association, but it has engendered a great deal of interest and support by the younger practicing osteopaths.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report, commending the committee for its farsightedness and sincere efforts in resolving one of the most difficult problems of the times.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MENTAL HEALTH

Benjamin Jeffries, MD, *Chairman*

The Committee appointed a representative to a special state legislative committee to study admissions, commitment procedures, and reimbursement rates for mentally ill children, adolescents and adults. Reviewed were the problems of drug purchases for indigents, abortions, and the Department of Mental Health's activities in Act 54 programs (Community Mental Health Service).

The Committee discussed the Psychologists Registration Act, heard a progress report on the new Forensic Center, and recommended its completion before the Department implements a proposal for joint facilities with the Department of Corrections. A report was given that the State Legislature is attempting to repeal the sexual psychopathic law.

The Committee reiterated a previous position that the Department of Mental Health initiate a cost for service basis instead of the current billing procedure of per diem rate charges. Also discussed were the financial liabilities of relatives of committed patients, a strategem to liberalize abortions, and a joint meeting with appropriate state legislators in late 1968. The Committee voted to continue an in-depth study of Strategy for Planned Educational Change (SPEC) after hearing a report.

Other matters reviewed and discussed were the use of generic equivalent prescriptions by state agencies, the 14th Annual Conference of State Medical Society Mental Health Representatives, community psychiatric centers, the future of large mental hospitals, the continuing problems of community mental health service programs, planned workshops in community psychiatry, legislative activities in mental health, mental retardation, alcoholism and drug abuse.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON OCCUPATIONAL HEALTH

William Jend, Jr., MD, *Chairman*

During the past year the Committee on Occupational Health was involved in the following matters:

1. *Review of written materials on Workmen's Compensation.* The Committee reviewed publications from other state occupational health committees and also studied the Wisconsin Occupational Health Guide with a view to similar publications in Michigan.
2. *Survey of county societies to determine which had an occupational health committee.* The Committee found that very few county societies had such committees, and deplored this condition in a major industrial state.
3. *Consultation with the Michigan Department of Labor.* This state agency asked for the advice of MSMS in developing physical examination standards for operating engineers. Subsequently, the Committee discussed informally with department officials in Lansing possible standards to assure maximum safety for the operator and the people who are working with him. Practical considerations in implementing such standards were also discussed.
4. *Consultation with the Department of Civil Service.* This agency requested MSMS help in formulating a physical examination benefit as part of a group health plan and, as with the Department of Labor, the Committee met informally with Civil Service officials in Lansing to discuss possible ways to achieve the objectives the department has in mind.

   The Committee is currently planning a meeting with the MSMS Committee on Alcoholism and Drug Dependence to discuss the problem of alcoholism in occupational health.

Also a future meeting will be planned with the Michigan Academy of General Practice to discuss matters of common concern.

In addition, the Committee will continue to help in the development of a possible program involving pre-employment medical examinations for MSMS employees.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Harry A. Towsley, MD, *Chairman*

During the year 1967-68, the Committee on Postgraduate Medical Education of the Michigan State Medical Society provided 37 programs in continuing medical education in 20 centers distributed geographically throughout the state; 12 were in the lower peninsula and 8 in the upper peninsula.

Registrations for the spring and fall sessions totaled 1,033 physicians of which 637 attended both the fall and spring meetings. Twenty-three of the programs held were combined live clinics with didactic presentations; fourteen presentations were didactic lectures only. Thirty-nine faculty members representing Michigan State University, the University of Michigan and Wayne State medical schools participated in these programs.

The Committee on Postgraduate Medical Education is deeply indebted to those faculty members who, with dedicated services, made possible continuing education for physicians enabling members of the State Medical Society to continue their education in the medical sciences at their own doorstep.

The Committee has repeatedly expressed its conviction that the greatest value is received from programs where clinical conferences with presentation and discussion of patients' problems in the local community are available.

During the year, one new center was added to the list: Livingston County. It is noteworthy that in Howell, Michigan, their program was attended by 43 physicians. There are 21 physicians who are members of the Livingston County Medical Society. The Committee wishes to recognize the sincere efforts put forth by the members of the Livingston County Medical Society in encouraging members of other county medical societies to attend this meeting.

Following is a list of faculty members and others who contributed to the program:

Richard J. Allen, MD
Thomas A. Bruce, MD
Oswald V. Clark, MD
Ralph J. Coskey, MD
Arthur C. Curtis, MD
Thos. J. DeKornfeld, MD
Reed O. Dingman, MD
Earl R. Feringa, MD
Stuart M. Finch, MD
F. Bruce Fralick, MD
A. James French, MD
Robert H. Gregg, MD
E. Richard Harrell, MD
Ruth Heyn, MD
Roland G. Hiss, MD
Robert B. Jaffe, MD
Benjamin Juliar, MD
Richard D. Judge, MD
Robert C. Kelsch, MD
George H. Koepke, MD
Richard O. Kraft, MD
S. M. Lindenauer, MD
Paul Lowinger, MD
George H. Lowrey, MD
Kenneth R. Magee, MD
George W. Morley, MD
Reed M. Nesbit, MD
Norman D. Nigro, MD
William R. Olsen, MD
Ananda Prasad, MD
Stewart E. Pursel, MD
Richard C. Schneider, MD
Edwin M. Smith, MD
Scott N. Swisher, MD
Harry A. Towsley, MD
Neal A. Vanselow, MD
David Watson, MD
Park W. Willis III, MD
Robert Wilson, MD
Walter P. Work, MD

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

Fredrick Weissman, MD, *Chairman*

Improvements in the MSMS Group Disability Plan. Several improvements in the MSMS Group Disability Plan were worked out by the Committee and the Provident Company. These include: (a) a reduction of premium for the the lowest age group (under age 34), (b) an increase in the available maximum indemnity from $500 to $1,000 monthly, (c) an insurability guarantee provision, (d) an extension of the disability benefit period for members under age 50 from age 65 to lifetime.

Disability Insurance for Employees of MSMS Members. This new group program, as developed by the Committee and approved by The Council, went into effect on April 1, 1968. The plan is underwritten by the Provident Life and Accident Company. It provides monthly cash benefits for enrolled employees of MSMS members who become disabled because of accident or sickness. A one-year accident — one-year sickness plan or a five-year accident — two-year sickness plan is available.

Adoption of New Blue Cross and Blue Shield MVF-2 Package Program. The Council on June 5, 1968, approved this Committee's recommendation that MSMS adopt the new Blue Cross and Blue Shield MVF-2 package. This program replaces the present M-75, and Over-65, group health programs available to MSMS Members. It offers an expanded scope of benefits and becomes effective August 1, 1968.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

Oscar D. Stryker, MD, *Chairman*

Smoking and Health. The Committee heard reports from the Committee on Public Relations and from the Michigan Council on Smoking and Health and very thoroughly discussed an educational program for physicians and the public on smoking and health. Because The Council had requested that a Task Force be appointed to set forth recommendations regarding such an education program, and because the Committee on Cancer had also recommended this be done, the Committee on Public Health assumed the responsibility and leadership in setting forth a recommended program of education that can be presented to The Council and subsequently referred to the Committee on Public Relations, the Public Relations Department, and the Michigan Council on Smoking and Health.

The Committee has requested the help of the Committee on Cancer and the Committee on Respiratory Diseases, and will submit its recommended program to The Council in the near future.

Radiation. The Committee has the addition of two advisors, R. C. Hildreth, MD, and J. E. Lofstrom, MD, to serve as liaison with the Radiation Section of the Michigan Department of Public Health.

The Committee is in favor of protecting the public and physicians from the hazards of defective radiation equipment, and has recommended that in problem cases the

Radiation Section of the Michigan Department of Public Health, consult with the Committee's Advisors on radiation who in turn can contact the physician in person or notify the local county medical society of the violation and if, after a contact is made, the physician still fails to comply with the regulations, that the Department contact the local law enforcement people.

Mumps and Measles Vaccines. The Committee discussed this matter with George H. Agate, MD, Chief of the Division of Epidemiology of the Michigan Department of Public Health, and requested him to write an article for *Michigan Medicine* on the "Pros and Cons of Mumps vaccine. Doctor Agate reported that there were no changes in the measles vaccine restrictions, and that the Michigan law will pretty much eliminate measles in this State within the next three years.

Screening Programs. The Committee reviewed the action taken by the 1967 House of Delegates regarding screening programs, and recommended to The Council that Item 3 of the "Guidelines for Health Screening Tests" be deleted inasmuch as screening procedures are being done in hospitals, by non-tax-supported institutions, and in some physicians' offices, and a fee is charged. The Council approved the re-wording of Item 3 in the "Guidelines."

Whooping Cough. The Committee reviewed the work being done in Michigan in connection with whooping cough in pre-school age children and those in the upper grades in high schools, and the attempts to work out a system where florescent antibody and culture tests are made available to all physicians.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PUBLIC RELATIONS

BROCK E. BRUSH, MD, *Chairman*

Workable, realistic public relations projects were developed and carried out this past year by the MSMS Committee on Public Relations and MSMS staff members —working closely with MSMS officers and committees, and also with component society officers and local public relations committees.

The Report of The Council includes brief references to several MSMS public relations and communications efforts.

The state committee this past year again sought to develop broad guidelines that the staff could implement by working with newspaper reporters and editors, with radio and TV executives and staffers, with printers and artists, with educators, with civic leaders, with politicians and elected state and federal officials, etc.

Career Recruitment: Every day this past year MSMS has been involved with continuing efforts to inform young people and their parents about the excellent career opportunities in medicine and health. MSMS again provided staff assistance and financial support to the Michigan Health Council for the continuance of its Health Careers Mobile. The Health Careers Mobile, with many new exhibits, visited county fairs, schools, college campuses, hospitals and spent considerable time in the Detroit inner city. Equally as important, MSMS continued its distribution of the authentic AMA "Horizons Unlimited" career handbook. Hundreds of books, with the eight special insert pages of Michigan information, were distributed to schools, colleges, youth-serving clubs and agencies, county health departments, and other outlets. Radio tapes, news releases, etc., all supplemented the MSMS desire to increase the health manpower available to serve the people of Michigan.

1967 Community Health Week: MSMS cooperated again with the AMA-sponsored Community Health Week, with the support in Michigan of the Michigan Health Council and the Michigan Association of the Professions. Major focus was on Michigan health manpower needs, with several county medical societies cooperating to present local programs before schools and with civic groups.

Quackery Education: MSMS sponsored two quackery education conferences this past year, one in Detroit during the MSMS Conference on Michigan Health Planning, and the other in Lansing for invited leaders from the Legislature, agencies, health organizations, etc. The MSMS Council in June adopted a new program in quackery education to reach Michigan children and adults.

Other Special Education Efforts: The Public Relations Committee and staff worked closely with several MSMS committees during the year in educational efforts. Informed physicians were placed before conventions and on radio and television programs, and copy was prepared especially for newspapers and magazines. The subjects included eye care, examinations for campers, pap tests, measles, inoculations, mental health, medical aspects of sports, abortion, poison, smoking-health, driver safety, and others.

Michigan Association of the Professions Formula Television Program: The PR Committee recognizes the many medical-related programs that have been produced by MAP over its weekly Formula television program over WJIM-TV in Lansing. Many MSMS officers and MSMS members, expert in various fields, have appeared as guests with Moderator Hugh W. Brenneman on the TV program.

Liaison with Woman's Auxiliary to MSMS and the MSMAS: Both the state Woman's Auxiliary and the Michigan State Medical Assistants Society provided MSMS with valuable assistance in legislation, education, and communications. The state Auxiliary and the local units were especially helpful again in career recruitment and the Medical Assistants worked to improve physician-patient relationships.

Distribution of Pamphlets and Films: Seldom did a week go by this past year that MSMS did not provide an educational film for some school assembly or civic meeting, or that MSMS did not distribute educational printed materials to teachers, professors, ministers, club leaders, legislators. As in the past, MSMS took advantage of the many fine publications produced by the AMA, Michigan Health Council, Michigan Council on Smoking and Health, AMPAC, etc. The films were utilized from the universities, national health associations, government, etc.

MSMS Radio Tape Series: MSMS continued to produce and mail 15-minute tapes about medicine and health each week to about 40 Michigan and midwest radio stations, thanks to the efforts of the MSMS Committee on Scientific Radio and WUOM at the University of Michigan. MSMS members discussed medical matters and good health practices. This is one of many on-going, quality MSMS public relations efforts that many physicians know little about.

Newspaper Cooperation: Almost every week, MSMS sent news material to Michigan newspapers, and to special writers from magazines and out-of-state newspapers. Close contact was maintained again with the 20 scientific writers on Michigan newspaper staffs.

Health-O-Ramas: MSMS and the three county medical societies in the large Detroit metropolitan area cooperated with the Michigan United Fund to support the career recruiting efforts of the four Health-O-Ramas held in the Detroit area. The Health Careers Mobile was a feature at each of the four week-long civic events.

Summary: The MSMS Public Relations Committee is proud of its work and efforts in so many different fields, and appreciates the excellent support it received this past year.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RESPIRATORY DISEASES

Richard A. Rasmussen, MD, *Chairman*

The Committee met with a representative of the Michigan TB and Respiratory Disease Association and reviewed mutual programs of medical and professional education and will cooperate in a program to emphasize to physicians the advantages of TB testing and prophylactic treatment of TB patients in physicians' offices.

The Committee is cooperating with the Committee on Public Health and the Committee on Cancer in formulating an educational program on cigarette smoking and health for presentation to The Council.

In the smoking and health field, the Committee is concerned with the education of school children and the cooperation of physicians in giving talks on this subject; has recommended full cooperation with the various groups and organizations having money to help in the education of the general public; and will consider ways of encouraging clean-up of cigarette advertising via publications, radio and television, especially when such advertising is aimed at youth.

The Committee has recommended that its original statement on air pollution previously approved by The Council be re-affirmed:

> "The Michigan State Medical Society, through its Committee on Respiratory Diseases, officially endorses the principle of reasonable and scientific study directed toward the sensible control of the major problems of air pollution, whether this be the dusts or wastes of industry, the products of combustion of gasoline or oil (automobiles) or the combustion products of home heating and burning equipment, or of smoking tobacco. All of these may have potential effect on man via the respiratory system and are, therefore, of concern to the physician, especially as they are known to affect health adversely."

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RURAL MEDICAL SERVICE

Robert E. Rice, MD, *Chairman*

The Committee has cooperated with the Michigan Health Council in its placement program, promoted the health career mobile, endorsed and implemented community health week, and attempted to influence the educational environment to improve the image of general practice and promote understanding of the realities of practicing in various sized communities. Resolutions were made promoting the training of personnel for emergency medical services and asking the medical schools to adopt preceptorship programs. The Committee is co-sponsoring, with the Michigan Health Council, a study as to why physicians choose their areas of practice and why they do not go to others. Other activities included the attendance and sponsorship of career conferences.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

William J. Ledger, MD, *Chairman*

This report is limited to a report on the radio program "Prescription for Health." This is a weekly fifteen minute program that had been sponsored by the State Medical Society. It is carried by at least fifteen radio stations in the State of Michigan. During the past year, the interviews have focused upon a number of problems of current medical interest. We have had programs on the problems of marijuana and LSD, genetics, the problems of septic abortion, newer forms of contraception, organ transplantation, obesity, inherited anemias, poisoning in the home, hearing defects, and current management of erythroblastosis fetalis. This wide range of subject material, I believe has been of interest to the listening public. In the future year, we plan to do a series on some medical implications of the traffic accident problem in this country. It is hoped that this will be an interesting and provocative series for the listeners.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report and urged the Committee to expand its efforts to include more stations and to make attempts to seek prime air time for its programs.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON THERAPEUTIC ABORTION

Howard R. Williams, MD, *Chairman*

Immediately subsequent to the adoption in 1967 of Resolution No. 40, as amended, directing that MSMS "work toward the revision and liberalization of the Michigan abortion laws," the House of Delegates recommended a formation of an MSMS ad hoc committee to review all available studies on the subject of therapeutic abortion and requested a report of findings to the 1968 House of Delegates.

The Delegates adopted the following reference committee report:

"In the opinion of your Reference Committee:

"1. Since therapeutic abortion is a current medical issue;

"2. Since therapeutic abortion is a departure from some medical philosophic concepts;

"3. Since therapeutic abortion is an emotionally charged issue;

"4. Since the subject of therapeutic abortion has been studied by: a) The American Law Institute; b) the American Medical Association, and those states in which a new program has been activated; c) by the American Psychiatric Association; d) by the Michigan Bar Association; e) and since a tentative position has already been rendered by MSMS in its August 28, 1967 testimony before our State Legislature;

"Your Reference Committee recommends the formation of an MSMS ad hoc committee to formulate a position statement on therapeutic abortion, incorporating all of the above studies, and to report their findings to this House of Delegates at its next regular session."

This ad hoc committee was duly appointed by the President of MSMS and, as charged, reviewed pertinent recommendations developed by the American Medical Association, the Michigan State Bar, the American College of Obstetricians and Gynecologists and several others. Legislation in this area unsuccessfully presented to the 1967 Michigan State Legislature was also studied, along with the testimony given thereon by affected state agencies and interested private groups and individuals.

Having considered the subject in depth, the committee discussed it in great detail and consonant with its charge by the House of Delegates and the President of MSMS recommends that the following statement on the liberalization of abortion laws be adopted by the 1968 House of Delegates as the present policy of the Michigan State Medical Society in regard thereto:

"Therapeutic abortion is a medical procedure. Accordingly, the Michigan State Medical Society recognizes its responsibility to render available scientific medical information with respect to therapeutic abortion to legislators, authorized committees, the public and, finally and most importantly, patients. Nowhere in the progression of therapeutic abortion legislation or practice should sight be lost of the fundamental principle that the primary decision belongs to the patient. This decision must be based upon an informed understanding of the nature and consequences of the therapeutic abortion, and should be coupled with the informed consent of the husband, if any, and the parents and/or legal guardian if the patient is a minor.

"The Michigan State Medical Society respectfully recognized that some physicians, because of moral or religious grounds, oppose liberalization of the therapeutic abortion laws. Therefore, no physician should be compelled, directly or indirectly, to perform a therapeutic abortion.

"In view of the above, the Medical Society believes that therapeutic abortion should be legally authorized subject to the following conditions:

"1. The procedure must be performed in a hospital licensed by this state; and

"2. Two other physicians, who must be medical doctors or doctors of osteopathy licensed in this state, chosen because of their recognized professional competence, must examine the patient and concur in writing that one of the three following conditions exists: a) There is documented medical evidence that continuation of the pregnancy may threaten the health or life of the mother, or b) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or c) There is documented medical evidence that continuation of a pregnancy, resulting from alleged statutory or forcible rape or incest, may constitute a threat to the mental or physical health of the patient, and the prosecuting attorney of the judicial district in which the alleged rape or incest occurred attests in writing over his signature that there is cause to believe that the alleged violation did occur."

The foregoing statement, it will be noted, emphasized the affirmative in certain circumstances as contrasted with a statement opposing therapeutic abortion except under certain circumstances. The ad hoc committee recommends that this statement be approved by the House of Delegates.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered the reports and recommended adoption of the first seven paragraphs and acceptance of the remaining paragraphs, as amended, as follows:

In view of the above, the Michigan State Medical Society believes that therapeutic abortion may be authorized subject to the following conditions:

1 — A licensed medical or osteopathic physician perform the abortion in an accredited hospital licensed by the State.

2 — Two other doctors of medicine or osteopathy concur in writing that one of the following conditions exists:

a) The abortion is deemed necessary to preserve the life of the pregnant female; or

b) The abortion is deemed necessary to preserve the physical or mental health of the pregnant female; or

c) That the infant may be born with incapacitating physical deformitory or mental deficiency; or

d) That three doctors of medicine or osteopathy believe that the pregnancy resulted from forcible rape or incest.

3 — MSMS does not condone the concept that an abortion be performed on demand for any unwanted pregnancy or as a means of birth control. We do believe, however, that in determining whether or not there is a risk to the pregnant woman's life or health, account must be taken of the patient's total environment, considering such factors as parity, contraceptive failure, socio-economic stress, or marital or family stress when a woman does request a therapeutic abortion.

The foregoing statement, it will be noted, emphasizes the affirmative in certain instances as contrasted with a statement opposing therapeutic abortions except under certain circumstances.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON VENEREAL DISEASE CONTROL

Frank B. Bicknell, MD, *Chairman*

1966-67 Committee Activity. The Committee's meeting of last year resulted in four of its recommendations being disapproved by The Council, with one recommendation referred back to the Committee.

The Committee's recommendation concerning serologic reporting of every positive STS still does not meet with the approval of The Council and will be reconsidered by the Committee at its next meeting.

The Committee agreed with The Council's disapproval of its recommendations concerning the reporting of venereal disease to local health departments and the requirement that all admissions to the in-patient services of hospitals receive an admission blood test for syphilis.

In considering last year's recommendation regarding the Government of Michigan recognizing its responsibility in the diagnosis, treatment and control of venereal disease, and to make meaningful appropriations toward this end, the Committee adopted a new recommendation, as follows: "Because 50% of the cases of reported gonorrhea and 34% of the reported cases of infectious morbidity of syphilis, come from the City of Detroit, and because the State of Michigan, at this time, provides only 0.5% of the financial support for the venereal disease control program in the City of Detroit, it is apparent that the City of Detroit suffers from a shortage of financial help. In addition, it appears that other local health departments, county and city, also suffer from a shortage of space, personnel and equipment, to deal with the ever expanding problems of venereal disease control, and that federal and local resources have proven to be inadequate. Therefore, the Committee requests The Council to recommend to the Michigan Department of Public Health that it involve itself, to a greater degree, in the control of venereal disease." This recommendation of the Committee was approved by The Council.

Educational Articles. The Committee has arranged for its members to submit articles and news notes for publication in *Michigan Medicine* and the other MSMS publications. The Committee has also recommended that the MSMS Public Relations Department continue the educational thrust done in October and November of 1966.

THE REFERENCE COMMITTEE on Reports of Standing and Special Committees, H. A. Towsley, MD, Chairman, recommended acceptance of the report with commendation.

THE HOUSE adopted the report of the Reference Committee.

19. Reports of House of Delegates Committees

COMMITTEE ON CERTIFICATES OF COMMENDATION

Marjorie Peebles Meyers, MD, *Chairman*

The MSMS House of Delegates established the "MSMS Certificates of Commendation" at its 1961 session. The Delegates instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first such "Certificates of Commendation" to four distinguished Michigan doctors of medicine who had been recommended by the House of Delegates Committee. The first four honorees were Jerome W. Conn, MD, Ann Arbor; G. D. Cummings, MD, Lansing; Charles S. Kennedy, MD, Detroit; and Robert L. Novy, MD, Detroit.

In 1963, the House of Delegates approved the report of the Committee and presented Certificates to Forest D. Dodrill, MD, Bloomfield Hills; Charles J. Jentgen, MD, Detroit; John M. Sheldon, MD, Ann Arbor; and Homer H. Stryker, MD, Kalamazoo.

The 1964 House of Delegates acted to present the certificates to Goldie B. Corneliuson, MD, Lansing; John S.

DeTar, MD, Milan; Robert Heavenrich, MD, Saginaw; Norman F. Miller, MD, Ann Arbor; E. Gifford Upjohn, MD, Kalamazoo; and Orus R. Yoder, MD, Ypsilanti.

In 1965, the House of Delegates approved Certificates to Fred J. Hodges, MD, Ann Arbor; Traian Leucutia, MD, Detroit; and Remus J. Robinson, MD, Detroit.

In 1966, the House presented awards to Arthur C. Curtis, MD, Ann Arbor; Lionel L. Davis, MD, Mt. Pleasant; Mark Marshall, MD, Ann Arbor; Harold J. Meier, MD, Coldwater; Ralph H. Pino, MD, Detroit; Alfred B. Swanson, MD, Grand Rapids; and Harry A. Towsley, MD, Ann Arbor.

The 1967 House of Delegates presented Certificates of Commendation to Frank J. Busch, MD, Saginaw; W. H. Huron, MD, Dickinson-Iron; Frederick Margolis, MD, Kalamazoo; David Sugar, MD, posthumously, Wayne; Raymond W. Waggoner, Sr., MD, Washtenaw; Charles H. Wright, MD, Wayne.

This year the Committee is proud to present for the consideration of the 1968 House of Delegates the names of five distinguished Michigan doctors of medicine for Certificates of Commendation. They are, alphabetically, A. Fleming Barbour, MD, Genesee; Harry L. Clark, MD, Mason; John M. Dorsey, MD, Wayne; Fred C. Sabin, MD, Marquette; and Wilbur D. Towsley, MD, Midland. Each was nominated by his county medical society, and was considered by the Committee along with other county nominations.

* * *

Brief biographic information follows about each man:

A. FLEMING BARBOUR, MD, Genesee

Born Elkhart, Indiana, July 28, 1909; Pre-medical education, Michigan State University, 1932; Medical degree, University of Michigan, 1936; Internship, Hurley Hospital, Flint; Residency, University of Michigan Hospital; Postgraduate, Rackham Graduate School, University of Michigan; MS Degree in Ophthalmology.

Twenty-eight years in practice in Flint; specialty Ophthalmology.

Hospital staffs: Hurley, Chief of the Department of Ophthalmology; also on McLaren and St. Joseph Hospital staffs.

Lieutenant Commander, U. S. Navy, 1943-46.

Medical Memberships: Member, Genesee County Medical Society, President in 1953-54; Member, AMA and Michigan State Medical Society; Member, American Board of Ophthalmology, American Academy EENT, Detroit Ophthalmology Society, Saginaw Valley EENT Association; Past President of Flint Academy of Surgery.

Community Service: Now State Chairman of YMCA World Services Program; Vice-Chairman, Board of Trustees of the Court Street United Methodist Church in Flint; Vice-President, Flint City Club. Former President of the following organizations — Flint Red Feather Fund; Greater Flint Council of Churches; Flint Committee on Alcoholism; University of Michigan Club of Flint. Former member of the following boards of Directors — Genesee County Chapter of the American Red Cross, Flint Family Service Agency, Flint Chamber of Commerce, Citizens Advisory Committee to Flint Board of Education, and other groups. He is a private sponsor of the Flint College and Cultural Development Program.

HARRY L. CLARK, MD, Mason County

Born Kingsville, Ohio, October 8, 1886; University of Michigan Literature School, 1906-1907; attended Medical School 1907-1909, leaving to teach high school for four years, assistant to Doctor Carl Huber in U. of M. Anatomy Department 1913-1917; completed A.B. in 1915, his A.M. in 1918 and his Medical Degree in 1919.

Following graduation from medical school, Doctor Clark became assistant professor of pathology and bacteriology at the Detroit College of Medicine in March 1919; appointed professor of bacteriology and clinical pathology in 1922 and continued until 1949, when appointed professor emeritus of that WSU department.

From January 1949 until 1957, Doctor Clark was director of clinical laboratories at Hackley Hospital, Muskegon; from 1957-1967, he was director of the laboratory at Paulina Stearns Hospital in Ludington; now is medical director of the Mason County Medical Care Facility.

Medical memberships; now president of the Mason County Medical Society; formerly a member of the Wayne County Medical Society and the Muskegon County Medical Society; active in other medical groups.

Member, Rotary Club, Masons, Shrine, Elks. Honored as "Optimist of the Year" in 1962 at Ludington.

JOHN MORRIS DORSEY, MD, Wayne County

Born Clinton, Iowa, November 19, 1900; Pre-medical education, University of Iowa with B.A. and M.S. Degrees; Medical Degree, University of Iowa, 1925; Internship, University of Iowa Hospital; Residency, University of Iowa Hospital; Postgraduate education, University of Vienna in psychiatry.

Hospital Affiliations: Harper, Receiving, Children's, Veterans Administration Hospital; Chief of Staff at McGregor Center.

Joined Wayne State University Medical School faculty in 1946; former professor and chairman, Department of Psychiatry. Now, "WSU University professor."

Author of Foundations of Human Nature, Living Consciously, Illness and Allness, The Growth of Self Identity, and many scientific articles.

Advisory psychiatrist to the Detroit Youth Commission.

FRED C. SABIN, MD, Marquette County

Born in Little Falls, N. Y., May 6, 1924; A. B. Degree from Syracuse University, and MD Degree from Albany (N.Y.) Medical College; M.S. Degree in ophthalmology from the Mayo Clinic and the Graduate School of the University of Minnesota; Fellow in ophthalmology at the Mayo Clinic from 1954 to 1957.

Served in U. S. Army, 1943-46, including 18 months in European Theatre.

Has practiced in Marquette since 1957. Affiliated with St. Lukes and St. Marys hospitals in Marquette.

Past President of Marquette-Alger County Medical Society; member of AMA and MSMS; Diplomate of the American Board of Ophthalmology, a Fellow of the American Academy of Ophthalmology and Otolaryngology.

Member of the Northern Michigan University Board of Trustees; member of State Board of Registration in Medicine; past chairman, Marquette County Republican Committee; former board member, Marquette Chamber of Commerce; member, Rotary Club, American Legion, Mason.

WILBUR DEAN TOWSLEY, MD, Midland County

Born June 7, 1897, Midland, Premedical Education, Kalamazoo College, B.S. Degree; Medical Degree, University of Michigan 1923; Internship, Grace Hospital, Detroit.

Has practiced in Midland 45 years. Father was Frank A. Towsley, MD, pioneer Midland physician; his brother, Harry A. Towsley, MD, is professor of pediatrics and chairman of the department of postgraduate medicine at the University of Michigan; and his brother, Charles Towsley, DDS, is a dentist in Midland.

Medical Memberships: Midland County Medical Society, President in 1936; Member of MSMS and AMA.

Served on State Boxing Commission in 1939.

Served on Midland Selective Service Board for more than 10 years.

Member of Midland Rotary Club for 36 years and Midland Elks.

Received "Book of Golden Deeds" award from the Midland Exchange Club, in 1962, when he was cited for having delivered more than 6,000 babies in Midland County, for helping many children and families in financial need, and for helping many students through medical school.

Keenly interested in fishing and hunting, Doctor Towsley is a Life Member of the Midland County Sportsman Club and a member of the Michigan United Conservation Club.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert S. Ideson, ii, MD, *Chairman*

Proposed Amendments re Procedures for Amending Bylaws. Following the one-day Special Session of the House of Delegates in February, 1968, when the Bylaws were amended, The Council received suggestions that existing amendatory provisions of the Bylaws be reviewed. Legal Counsel was asked to suggest clarifying language and the entire matter was referred to the Constitution & Bylaws Committee.

The Committee concluded that the founding fathers probably intended that amendments really be put over for studied consideration and did not envisage the House holding two meetings minutes apart for the purpose of amending the Bylaws.

Therefore the Committee recommends the following amendments to Chapter 9, Section 1 — Amendments: (New language in caps)

> Sec. 1 AMENDMENTS — PROCEDURE — These Bylaws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table UNTIL THE NEXT SESSION, UNLESS, BY UNANIMOUS CONSENT OF THE DELEGATES PRESENT AND VOTING, SUCH TIME REQUIREMENT IS WAIVED, IN WHICH EVENT THE SAID AMENDMENT MAY BE VOTED UPON AT THE NEXT ~~for one~~ meeting of the House of Delegates. THE AMENDMENT OR AMENDMENTS TO these Bylaws ~~and any amendments thereto~~ become effective immediately upon adoption.

Proposed Review of Constitution. It became evident during the 1968 Special Session that there were apparent language conflicts between the MSMS Constitution and its Bylaws. So much confusion existed that Legal Counsel had to interpret points in each document for the benefit of the entire House. He stated to the Delegates at that time that the Constitution, written when MSMS was organized, properly served as the document expressing MSMS goals, purposes and reasons for being. In addition, it contained a few general statements re structure which are defined and clarified in the Bylaws. Then, in 1910, MSMS incorporated and, in so doing, filed with the State its statement of purpose in its incorporation papers. Thus the need for a Constitution disappeared, although no real problem occurred until 1968.

Over the years, the Bylaws have been continually refined and clarified, but the Constitution remains, unheeded and unneeded, since the organization's purposes are now outlined in the incorporation papers.

Legal Counsel therefore suggested to the Delegates in February that the House might well consider the abolition of the Constitution and transfer of any desired statements into the operating Bylaws. The Speaker concurred that the Constitution and Bylaws Committee should consider the suggestion.

The Committee has discussed the matter and generally favored the idea of reviewing the need for and value of the Constitution. It was specifically pointed out that such a study did not include a rewriting of the Bylaws. Clarifying amendments might be found necessary, but no more so than during any annual review.

The Committee was particularly sensitive to potential misunderstanding of the high purpose and limited scope of the proposed study. It feared that misunderstanding would produce suspicion of motives and thus doom the project before it began. Therefore, the Committee chairman agreed to have introduced a resolution in behalf of the Committee alerting the House to the Committee proposal and seeking House concurrence.

The Committee therefore specifically recommends that such a study be conducted, that progress on the study be reported periodically and a proposed revision be presented to the House, possibly in 1969, with final action possible by 1970 or 1971.

Correspondence re Elections. The Judicial Commission corresponded with the Committee suggesting that it consider revision of the method of electing Councilors. The Committee discussed the matter and alternatives to the election by the House. No action was taken.

Suggested Study of Methods of Membership Transfer. Since problems do occur when a member transfers from one component medical society to another, The Council has suggested that this matter might be studied with an eye to clarifying Bylaws language. The Committee has this on its agenda.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of this report with the following amendments:

"The proposed amendment to Chapter, 19, Section 1 of the Bylaws be amended by deletion of the words 'by unanimous consent,' and the insertion of the words 'by consent of 75 percent of.'"

"In regard to the proposed review of the Constitution . . . your Reference Committee would recommend a continuing review of the Constitution but not with a view of its abolition."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL STAFF SURVEY OF HOSPITALS

Rosser L. Mainwaring, MD, *Chairman*

No business came up before this Committee. The Committee did not meet.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended the report be accepted.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROCEDURES OF THE HOUSE OF DELEGATES

Noyes L. Avery, MD, *Chairman*

This Committee has functioned each year since 1963 for the purpose of reviewing the operations of the House of Delegates and formulating recommendations to the Speaker designed to improve the efficiency of that body wherever possible.

The foremost guideline of the Committee has always been its priority placed upon the provision of adequate time for the conducting of the major business of the House itself, so that Delegates may have ample opportunity to fully consider and debate matters brought before them. The Committee is unanimously persuaded that experience has shown that the volume of business has become such that *more time is needed* for the deliberation and reporting of reference committees.

The Committee notes that since 1965 the deadline for submitting resolutions has been fixed at the third session (Monday night) except by unanimous consent of the Delegates. It is felt that an intensified effort should be made to encourage all to submit their resolutions before the House convenes, so that they may be printed and studied by Delegates in advance. For the 1968 meeting, however, the Committee recommends that no resolutions be accepted after the *second* session (Monday morning) except by consent of two-thirds of the seated Delegates. While still permitting the introduction of resolutions which may be deemed necessary while the House is in session, it is felt that this change in the order of business will advantage all Delegates by providing more deliberative time. This will be more easily accomplished when it becomes possible to start the sessions one week later than has been the case in the past, allowing more time for county societies to meet in the early Fall (see recommendations of this Committee in 1967).

It has been stated above that the Committee feels that the House has reached the point where it needs more overall time in which to function. This time may be added by holding the first session commencing at noon on Sunday rather than Sunday evening; it may be added by meeting on Wednesday morning (when the scientific meetings have commenced). Although the Committee is not now recommending any major time addition or rescheduling of the order of business of the House, it suggests that in future years commencement at noon on Sunday may be preferable to commencing on Sunday evening or extending the meeting to Wednesday noon. Under such circumstances resolutions would be submitted before the close of the second session (Sunday evening) with provision for exceptions.

The Committee also noted that, although the President of MSMS is elected by the House of Delegates, it has been many years since the House itself has had the honor of conducting his formal inauguration. Feeling that the Delegates would be enthusiastic about doing so, and convinced that a ceremony befitting the investiture of the MSMS President can best be performed before his peers at a specially designated meeting of the House, the Committee is recommending that this ceremony take place during a new function, a dinner meeting on Tuesday evening. The State Society Night program formerly held on Wednesday evening, during which the President has been inaugurated for the past several years, will be revamped accordingly.

It is recommended that the dinner meeting of the House on Tuesday evening be designated the fifth session, preceded by a preprandial commencing at 5:30 pm, and be held at 6:00 pm, ending at 8:00 pm with the sixth session of the House. It is further recommended that attendance at the dinner be determined by the Speaker at his discretion, and that certain other appropriate business of the House also be transacted at this time, including the designation of Michigan's Outstanding Physician, awarding of MSMS Certificates of Commendation, and other awards of similar stature. The Committee further recommends that all honored guests attending the House meeting be invited to, and introduced at, this dinner meeting.

Finally, the Committee notes that the Michigan Medical Service corporate meeting will be conducted during Tuesday morning and end with a luncheon during the 1968 meeting, rather than continue into Tuesday afternoon. The Committee approves this change, feeling that it will expedite the business of the House itself, providing better scheduling for reference committee meetings, and hopes that the MMS meeting itself can be expedited particularly by devising a speedier method of certifying electors.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, accepted the report and recommended further implementation of its suggestions be made as soon as possible.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE

John G. Slevin, MD, *Chairman*

Because of the marked increase in malpractice claims in recent years, the House of Delegates established the Committee on Professional Liability Insurance in 1966. The present Committee investigated what is being done in other states to lessen the frequency of such suits.

Probably the most widely discussed program is the *Joint Attorney-Physician Review Panel* which was initiated more than ten years ago in Pima County, Arizona. This is a joint panel of lawyers and physicians set up by the local Bar Association and the County Medical Society. It is a pre-trial hearing with the plaintiff and the defendant physician and their attorneys presenting the evidence. The panel finds either that there is or is not substantial evidence of malpractice. If the answer is "yes" and if an equitable claim adjustment cannot be reached out of court, the medical society agrees to produce expert medical witness at the trial.

Our Committee found that a negative verdict by the Joint Attorney-Physician panel did not preclude the plaintiff going to court. Among the hazards to the defendant physician was the exposure of all the records of the case to the plaintiff's lawyer, making the defense against the malpractice claim more difficult. Our Committee noted that in 1967 premiums for professional liability in Arizona rose fifty percent, the highest increase in the country.

A number of other states have tried the Pima County Panel system only to abandon it because it did not achieve its purpose, namely, a reduction in the number of malpractice claims and increased the cost of professional liability insurance.

The New Jersey Plan was considered. It is set up under a rule of the New Jersey Supreme Court and consists of a joint panel of lawyers and physicians with a retired judge presiding. All records of the hearing are confidential and cannot be turned over to another lawyer or the courts. If the panel decides against the claimant, his attorney must withdraw from the case. However, the plaintiff can obtain another lawyer and take the case to court. A report from the New Jersey State Medical Society on the operation of the plan was favorable. However, there was not enough data at present to evaluate the effectiveness of the New Jersey Plan.

The Oregon State Plan was also studied in depth. The state medical society has sponsored malpractice insurance through private underwriters since 1933. This was on a single premium policy until 1967 when the increase in claims and the amount of settlements and court awards forced a change to a differential premium based on the field of practice. Premiums varied from $190.00 to a high of $693.00. The high rate was for anesthesiologists, neurosurgeons, obstetricians, gynecologists, orthopedic surgeons, plastic surgeons, and otolaryngologists who perform plastic surgery. This corresponds with the new category established by the National Bureau of Casualty Underwriters which determines premium rates on professional liability insurance for its affiliated companies. The NBCU blamed the premium increase on the rising cost of malpractice claims especially in these specialties.

The NBCU indicated that its affiliated companies sustained ever increasing losses which amounted to $140.00 for each $100.00 in premiums; that losses and expenses for surgeons totaled $151.00 for each $100.00 in premiums.

According to reports published in the AMA News, the insurance rates for physicians' and surgeons' professional liability insurance has been raised during the past year in 38 of the 50 states as follows: Arizona, 50%; Washington, 48%; California, 32%; Colorado, Delaware, Hawaii, North Carolina, Puerto Rico, Utah, 30%; Florida, 26.3%; Minnesota, Texas, 25%; New York, 21%; Maryland, Michigan, Montana, New Mexico, Oregon, Pennsylvania, Rhode Island, Virginia, 20%; Alabama, 16%; Arkansas, Missouri, Wisconsin, 15%; Connecticut, Georgia, Idaho, Iowa, Kansas, Kentucky, Ohio, Oklahoma, South Carolina, Tennessee, West Virginia, Wyoming, 10%; New Hampshire −10%.

Ontario and most Canadian provinces, it was noted, have a much lower incidence of malpractice claims. Inquiry was made why this is so. It seems that under Canadian law, when a plaintiff files a malpractice suit, he is required to post a bond covering court costs and attorneys' fees. If he loses his suit, the bond is forfeited. Our legal advisors explained that in Canada the legal profession is not allowed to work on a contingent fee basis whereas this is the customary procedure in American jurisprudence. The Committee was informed that the contingent fee system seeks to give the poor man his day in court and is approved by the majority of American lawyers. Legal advice was that the chances of adopting the Ontario plan in Michigan was nil.

Action being taken by the California Medical Association to lead to a better "professional liability atmosphere" in that state was considered. The CMA sponsored six professional liability bills in the state legislature. Several of these bills were considered as worthy of introduction in the next session of the Michigan Legislature and will be noted under Recommendations.

Educational Programs for Physicians. A survey of the programs of the various states which have had committees to study the malpractice problem reveals that education of the physician is needed so that he may avoid the common problems leading to malpractice claims. Members of this Committee from Wayne County reported that as a result of meeting with lawyers who defend eighty percent of the malpractice claims in the Detroit Metropolitan area, the need to educate the physician in medico-legal matters was, in their opinion, paramount. They indicated that more malpractice claims originate because of loose talk or criticism by physicians about the actions of other physicians, than from any other cause.

RECOMMENDATIONS:

1. That county medical societies, and in large areas, hospital medical staffs, be urged to hold at least one meeting annually devoted to medico-legal problems conducted by an attorney knowledgeable in the field, with emphasis on procedures to lessen the causes for malpractice suits.
2. That the MSMS Legislative Committee formulate a bill to be introduced at the next session of the Michigan Legislature to exempt from subpoena or compulsory disclosure of its actions or proceedings committees of hospitals, state or local medical societies all information and reports furnishing such committees for statistical, scientific, educational or medical study or research directed toward the reduction of morbidity or mortality, utilization, audit of medical care, etc.
3. That physicians, particularly those in the high risk category, be urged to consider carrying excess professional liability, over and above their regular professional liability coverage, the so-called "umbrella policy," which provides at least $1,000,000 over present coverage. It was noted that a number of malpractice awards during the past year have far exceeded the usual $100,000 coverage normally carried by most high risk insurees. They have varied from $200,000 to as high, in one instance, as $1,400,000. Since the cost of such supplemental coverage can be substantially reduced by group insurance through medical societies, as has been demonstrated by some of the larger county medical societies, it is further recommended:
   a. That the MSMS Committee on Professional Insurance Plans investigate the possibility of establishment of such a group supplemental personal catastrophe policy for members of MSMS.
   b. That the MSMS Committee on Professional Insurance Plans continue to investigate feasible plans for reduction of malpractice rates. This study should include the feasibility of MSMS sponsoring a "doctor-owned" professional liability carrier such as was done in 1957 by the Colorado Medical Society and is now being considered by the California Medical Society. It is also recommended that this MSMS Committee make a definitive report to the 1969 MSMS House of Delegates on these items.
4. Because there are many other matters which need study, such as, what can be done to protect the physician from harrassment by nuisance claims; could malpractice claims submitted to arbitration be binding on both parties thus precluding court action, etc., it is recommended that this Committee be continued and become a permanent committee of the House of Delegates.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, accepted the report, recommending: no action on Recommendation One, since this House has already acted on Res. 17; no action on Recommendation Two, since this House has already acted on Res. 46; and approval of Recommendations Three and Four.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO RE-EVALUATE THE DUTIES OF THE PRESIDENT

C. Allen Payne, MD, *Chairman*

The 1967 House of Delegates adopted a reference committee recommendation that "an ad hoc committee of the House . . . be appointed to re-evaluate the executive duties of the President."

The Committee met on two occasions. It reviewed the present function of the President as outlined in the Bylaws as follows: As the general executive officer of the Society, the President shall preside at General Meetings of the Society, deliver the President's Address, appoint necessary committees where not otherwise provided for and, in addition, shall have a voice in deliberations of the House; shall be an ex-officio member of The Council with vote; and perform such other duties as imposed by the Bylaws.

The Committee recognized that the presidency is the highest honor which the Society can bestow upon a member.

In its study the Committee reviewed several other state medical society organizational structures. Wisconsin, Illinois, and Pennsylvania have presidential responsibilities similar to Michigan. (See Addendum.)

The Committee also reviewed the MSMS tradition and practice of sharing duties and responsibilities among the Speaker of the House of Delegates, the President and The Council Chairman, according to Bylaws direction.

Several proposals for modifying the president's duties were reviewed, and no consensus was established. However, the Committee wished to present to the House a possible solution which it felt deserved more detailed study. The idea, in general, is to provide for the President-elect to serve as Vice-Chairman of The Council, and the Immediate Past President to serve as Chairman of The Council.

Additional study of this and other suggestions is required before any specific recommendations can be made, for undoubtedly a thorough restructuring of the Bylaws would be required before such an amendment could be adopted.

ADDENDUM:

Excerpt from Bylaws of the State Medical Society of Wisconsin:

"The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state, during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful."

Excerpt from Bylaws of the Illinois State Medical Society:

"The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

"The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

"He shall preside at the general scientific meetings of the Society or designate one of the vice presidents to substitute for him."

Excerpt from Bylaws of Pennsylvania Medical Society:

"President. The President shall preside at all general meetings of this Society. At the first meeting of the Annual Session of the House of Delegates he shall deliver an address on such matters as he may deem of importance to this Society, and file a written report on his term as President. He shall be an ex-officio member of all committees, administrative councils and commissions, without the right to vote, and he shall perform the other duties required of his office by the Constitution of the Society and these Bylaws."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended no action, because additional study of this and other suggestions is required before any specific recommendations can be made, for undoubtedly a thorough restructuring of the Bylaws would be required before such an amendment could be made.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO SELECT MICHIGAN'S OUTSTANDING PHYSICIAN

D. Bonta Hiscoe, MD, *Chairman*

The House of Delegates in 1964 took action "to establish annual recognition of Michigan's Outstanding Physician." The resolution outlined this award "as an annual recognition of a member of the profession, who is not necessarily a family physician nor one advanced in years." The delegates also adopted the report of the reference committee which instructed "that the Speaker annually appoint an ad hoc committee to make the selection from nominations submitted by component medical societies."

In 1965 our first outstanding physician was Franklin L. Troost, MD, of Holt. In 1966 William A. Hyland, MD, of Grand Rapids received the award posthumously. Last year Henry Cook, MD, of Flint was our Outstanding Physician of the Year.

The present Committee sent invitations to each component medical society, seeking nominations. The Committee carefully evaluated the many accomplishments and contributions of a number of very worthy nominees.

During our deliberations we drew up a set of guidelines. Briefly, they follow:

1 — Big city vs. outstate politics had no bearing on this matter.

2 — MSMS represents all doctors, academic, public health, administrative, as well as practicing physicians, and all fields should be considered equally.

3 — This physician should be outstanding in his own particular field.

4 — This physician should demonstrate a real sense of social responsibility.

5 — This physician should show a sense of loyalty to the medical profession and the Michigan State Medical Society.

6 — This award gives us an opportunity to use the high-power focus on an example of the type of physician MSMS is most proud of.

Your Committee's nominee for this year was born in New York City and attended Hunter College in New York; was graduated from Wayne State University Medical School in 1943; served an internship and a residency in Internal Medicine at Receiving Hospital, and has practiced in Detroit ever since.

Active in medical society work, our nominee is a delegate from the Wayne County Medical Society and an MSMS alternate delegate to the AMA House of Delegates. This doctor is active on several MSMS committees and also in the Wayne County Society, serving several years as an associate editor of the *Detroit Medical News*.

This physician is an excellent teacher and serves as a clinical assistant professor of medicine in Wayne State University Medical School.

Our nominee has a long, impressive record of volunteer service to the people of metropolitan Detroit and Michigan. This physician now serves as a vice-president of the Michigan United Fund, a Board member of Boy's Republic, a Board member of the Michigan Heart Association, a Board member of the Rehabilitation Institute, Treasurer of the Detroit Adventure cultural organization, a member of the Detroit Committee on Alcoholism, a long-time worker for the Detroit YWCA, the Detroit Neighborhood Service Organization, the Michigan Society for Mental Health, and other civic, health and educational groups.

Recently this physician was honored as one of the "Top Ten Detroit Women Who Work."

Her husband serves the Cathedral Church of St. Paul in Detroit as canon. She is the first and only woman member of the Standing Committee for Advice and Counsel to the Bishop of the Diocese of Michigan of the Episcopal Church.

The House of Delegates Committee to Select Michigan's Outstanding Physician of the Year enthusiastically urges the 1968 MSMS House of Delegates to approve our nomination of Doctor Marjorie Peebles Meyers because she is a distinguished physician, medical educator, medical statesman, and a dedicated community leader.

THE HOUSE, acting as a committee of the whole, adopted the report of the Committee.

COMMITTEE TO STUDY FINANCIAL STRUCTURE OF MSMS

James D. Fryfogle, MD

The Committee reviewed its 1967 report and reaffirmed the Committee's responsibilities stated therein:

> "It must 1) review all aspects of the financial structure of MSMS, 2) determine that monies are efficiently administered, and 3) assure itself that funds are adequate for the job to be done. The Committee decided not to comment on the worth and value of projects or activities since these are annually reviewed by the House through reports from The Council and committees."

The study plan for 1968 was much the same as in 1967, except that since this Committee reports every year, rather than at the former three-year interval, the Committee believed it need not report its detailed 1967 study of the operational mechanics of the MSMS budgeting and control system.

The Committee did review thoroughly the current MSMS Financial Report for the nine months ending August 31, 1968, reviewed projected operating budgets for 1969 and 1970, and devoted a major portion of its study time to the status and operation of the MSMS Asset Management Plan.

The Committee was satisfied that the monthly financial reports provide the Finance Committee and The Council with adequate information to maintain expense control and make informed financial policy decisions. It also was noted that the financial control system would produce a balanced budget again in fiscal 1968.

In addition, the Committee studied preliminary figures developed by staff, projecting operating budgets for 1969 and 1970. Briefly, the figures showed a normal increase in income, but a greater increase in projected expense. The Chairman produced examples of 1968 cost increases which have an effect on the budget:

	1967	1968	% increase
First class postage	5¢	6¢	20%
White punched mimeo paper	$1.44/ream	$1.58/ream	10%
Colored punched mimeo paper	$1.52/ream	$1.65/ream	9%
Stencils	$3.20/quire	$3.45/quire	8%
Groundskeeping	$3.25/hour	$4.00/hour	23%
Window-cleaning	$58/month	$63.80/month	10%

The bulk of the Committee's study was devoted to the new Asset Management Plan which was approved by the House in Special Session in February, 1968.

Doctor John Ylvisaker met with the Committee and went into detail regarding the implementation of the program since approval in February.

Briefly, the funds obtained by mortgaging the building will be apportioned to three MSMS funds, maintained as separate entities, with purposes and goals as follows:

Operating Fund.

a. To maintain adequate funds for day-to-day operating expenses of the Society on a pay-as-you-go basis.

b. To invest surplus, during peak income periods, in short-term fixed-dollar securities to provide maximum interest return and to provide for the programmed release of these investments to meet operating needs during low-income months.

Capital Reserve Fund.

a. To augment present Capital Reserve to $250,000.

b. To provide for maintenance of Reserve at a minimum level equal to:

1. Two-months operating expenses.
2. Additional sum equal to accumulated depreciation plus 10% of building contents.
3. Additional sum equal to 10% of replacement value of headquarters building.

c. Investment of funds:

1. 50% in fixed-dollar negotiable securities providing maximum interest income.
2. 50% in high-grade negotiable securities providing income and growth.

d. Replenishment and augmentation of fund principal by income and growth of the fund or by appropriation from operating funds when necessary.

Creative Reserve-Capital Protection Fund.

a. Created from balance of mortgage monies after providing for needs of Operating Fund and Capital Reserve Fund.

b. Investment of funds:

100% in bona fide investment vehicles to provide balanced portfolio of stocks, bonds, real estate or others resulting in growth, income and stability.

c. Maintenance and augmentation of fund by growth of asset value or by reinvestment of profit, gain or unused interest or dividend income.

d. Distribution of income:

1. To provide other than ordinary service to Society members.
2. For creative Society projects consonant with Society aims and objectives.
3. For research appropriate to 1 and 2.
4. For expenses incurred in management of the fund.

The investments are superintended by a Council-elected Board of Managers composed of physicians and financial experts. It reports to the Finance Committee and The Council.

The Committee agreed with the fund goals and plans and was satisfied with the exercise of authority and control over the funds by the Board of Managers and The Council, and praised the Treasurer for his experienced guidance of the entire plan.

CONCLUSIONS:

1. The MSMS Asset Management Plan is efficiently operated and represents a substantial improvement in the MSMS approach to present and future fiscal responsibility. The Committee approves of the manner in which the plan is being operated and in the goals the funds are set up to achieve. Particularly the Committee is impressed by the safeguards built into the fund management by Treasurer Ylvisaker and his Committee.
2. After a review of the 1967 year-end Financial Report and the 1968 nine-months report, the Committee believes the financial structure of MSMS is adequate to provide the funds to do the job required. In the long term, however, the Committee sees income rising more slowly than expense and a dues increase seems certain by 1970 or 1971.

THE REFERENCE COMMITTEE on Ways and Means, S. N. Kelso, MD, Chairman, recommended approval of the report, seconding the Committee's commendation of the performance of our Treasurer, Dr. John Ylvisaker.

The HOUSE adopted the report of the Reference Committee.

RESOLUTIONS

THE HOUSE adopted a motion that no new resolutions be introducd after the Monday morning meeting except by consent of two-thirds of the seated delegates.

RESOLUTION 1

Objection to Unnecessary Paperwork
Introduced by Donato F. Sarapo, MD

Whereas, the ever mounting volume of documentation required in the modern practice of medicine greatly diminishes the time available for patient care, and

Whereas, the medical profession already is becoming desperately short of time and physicians to care for the nation's sick people, and

Whereas, the number of certifications, signatures, and diagnoses on every laboratory and X-ray request covered by Michigan Hospital Service, Medicare, and various other insurance carriers adds a great deal of unnecessary documentation in an apparent attempt to make certain requested examinations are necessary, and

Whereas, if any questionably necessary procedures were to be ordered by the attending physician, they almost certainly would be properly documented, therefore be it

RESOLVED: That this House of Delegates of the Michigan State Medical Society instruct The Council of MSMS to advise all insurance companies and carriers operating in the State of Michigan that the members of MSMS consider this requirement of signatures, certifications, and diagnoses on each and every laboratory and X-ray procedure to be detrimental to the best interests of adequate patient care in this State, and be it further

RESOLVED: That this House of Delegates instruct The Council of MSMS to advise these same insurance companies of the desire of MSMS members to have this requirement withdrawn in the best interests of patient care, and be it further

RESOLVED: That this House of Delegates instruct The Council of MSMS to advise the individual members of MSMS that the best interests of patient care will be served by the members no longer providing these unnecessary and time consuming signatures, diagnoses, and certifications effective in the immediate future, and be it further

RESOLVED: That a similar resolution be presented to the House of Delegates of the American Medical Association by the Delegates from MSMS at the earliest opportunity.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman considered Resolution 1 and 61 together, and recommended adoption of the following substitute resolution:

Whereas, there is an ever-increasing burden of unnecessary documentation of medical services by the physician, hospital and fiscal intermediary in Medicare and Medicaid patients, and

Whereas, this detracts from the optimal care of the patient, and

Whereas, this unnecessarily increases the cost of patient care, therefore be it

RESOLVED: That the Legal Affairs Committee of the Michigan State Medical Society exert every effort to bring about the elimination of these unnecessary procedures.

THE HOUSE approved the following substitute Resolved and adopted the substitute resolution as amended:

RESOLVED: That this resolution be presented to the MSMS Council and the AMA House of Delegates at the earliest opportunity.

RESOLUTION 2

Legislation re Malpractice Suits

Introduced by Edward E. Elder, Jr., MD

Whereas, the cost of malpractice insurance has risen so markedly, and

Whereas, the judgments awarded in malpractice suits have reached astronomical figures, and

Whereas, many suits against physicians are nuisance suits designed to obtain money on out of court settlements, therefore be it

RESOLVED: That the Michigan State Medical Society urge the State Legislature of Michigan to enact legislation requiring the posting of a bond by a claimant in a malpractice action, as a step to reducing baseless lawsuits against physicians. For example, a $500 bond filed by the claimant might be awarded the defendant for defense costs, if the verdict is for the defendant physician.

THE REFERENCE COMMITTEE on State & Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution and referring it to The Council for appropriate implementation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 3

Regional Councils of the State Comprehensive Health Planning Commission

Introduced by Robert J. Toteff, MD

Whereas, Public Law 89-749 authorizes regional councils of the State Comprehensive Health Planning Commission, and

Whereas, this Commission will be directing the utilization of federal funds in the local areas, and

Whereas, this Commission will be directing the expansion and building of health care facilities, and

Whereas, the county medical societies through their members will be acutely concerned with working with the directions and decisions of the Commission, and

Whereas, the appropriate information concerning this is not yet available to the county societies, therefore be it

RESOLVED: That the county societies be made cognizant of the role to be played by them in the regional councils of the State Comprehensive Health Planning Commission, and be it further

RESOLVED: That this information with recommendations be made available to the county societies at the earliest date possible following the 1968 House of Delegates Meeting of the Michigan State Medical Society, and be it further

RESOLVED: That the Michigan State Medical Society strongly recommend that the local county societies be involved and take a prominent part in the formation of the regional councils of the State Comprehensive Health Planning Commission, with the aim of having adequate medically oriented representation.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, amended the first Whereas, inserting after the words "Public Law 89-749," the words "as amended by Public Law 90-174," and amended the Resolved section by deleting the third Resolved and amending the first and second Resolved portions to read:

RESOLVED: That the county societies be made cognizant of the role which can be played by them in taking leadership in the regional councils of the State Comprehensive Health Planning Commission, and be it further

RESOLVED: That this information with recommendations by The Council be made available to the county societies at the earliest date possible following the 1968 House of Delegates meeting.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 4

Constitution and Bylaws Committee Report

Introduced by Henry A. Scovill, MD

Whereas, the Constitution and Bylaws Committee report contains an important recommendation relative to clarifying language in the Constitution and Bylaws and the Articles of Incorporation, and

Whereas, the Constitution and Bylaws Committee seeks approval for a proposed review of these three documents, therefore be it

RESOLVED: That this House of Delegates take due note of this recommendation and give favorable consideration to the Committee's report.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval, stating it felt it unnecessary to petition the House to consider any committee report.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 5

Michigan Medical Service Assignments

Introduced by H. T. Knobloch, MD

Whereas, Michigan Variable Fee Policy is completely new and different from previous policies, and

Whereas, a physician will not know the amount which will be paid for his services, and

Whereas, the fees paid under Medicaid by Michigan Medical Service are not a physician's usual and customary fee, and

Whereas, the changes in the policy remove M.V.F. from under the consent decree prohibiting assignment of fees to the physician, therefore be it

RESOLVED: That MMS shall honor assignments of fees to physicians under MVF policies, and be it further

RESOLVED: That if MMS refuses to accept assignments, MMS shall take the proper legal action forthwith to show that MVF is not bound by the consent decree.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution because the assumption in the last Whereas is in error according to Legal Counsel.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 6

Family Planning

Introduced by Robert R. Dew, MD

Whereas, population growth during the first 600,000 years of man's existence was 0.02% per 1,000 years, and only 0.06% per year by the year 6,000 B.C., but the rate of increase in the last three centuries alone has been phenomenal — 0.3% in the period 1650 A.D. to 1750 A.D., 0.9% in the first half of the twentieth century, 2% now and expected to be 2.1% by 1975, and

Whereas, it has been calculated that 100 persons, multiplying at 1% per year for the 5,000 years of human history, would have produced a contemporary population of 2.7 billion persons per square foot of planet land surface (had all lived to maturity and procreated offspring); and

Whereas, war, famine, disease, etc. have in centuries past been checks on population expansion, public health and hygiene and medical advances have been primarily responsible for the relatively recent population explosion, and

Whereas, although public health and medical scientific advances have contributed mightily to longer and better life, they have coincidentally contributed to problems of the greatest magnitude, an example of which is illustrated by the statistical fact that although the economically deprived say that they wish to have fewer children than the economically privileged, they actually have about 40 children per 1,000 population as compared to about 22 children per 1,000 for the well-to-do, and

Whereas, over 250,000 babies are born in the U.S. each year to unmarried women, about 9 out of 10 label their children "unwanted", and

Whereas, although the numbers of unplanned pregnancies in marriage can only be estimated, nonetheless it is a fact that unplanned pregnancies too often produce unwanted and thus rejected, abandoned or battered children, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates go on record as being in favor of universal family planning as an essential element of responsible parenthood, stable family life and social harmony and further that we recommend that each member actively participate to the best of his ability and opportunity.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 7

Need for Cooperation between MSMS and MHA

Introduced by D. Bonta Hiscoc, MD

Whereas, Michigan State Medical Society and Michigan Hospital Association are both very important parts of the medical community as it exists today, and

Whereas, both organizations have a vested interest in the future of medical practice, and

Whereas, both organizations are dedicated to fostering as little government involvement in medicine as possible, and

Whereas, combined efforts are often more effective in problem-solving and more influential in the public forum, therefore be it

RESOLVED: That closer cooperation be actively promoted between MSMS and MHA at both the state and local society levels, and be it further

RESOLVED: That when there are differences between the two societies about medical care or its administration, we make vigorous efforts to resolve these problems between ourselves, to preclude the arbitration of medical debates by the legislature.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, added a third Resolved which read, "RESOLVED: That a liaison committee be established between MSMS and MHA to implement this resolution", and recommended adoption of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 8

Investigation of a Doctor Convicted of a Felony

Introduced by Arnold L. Brown, MD

Whereas, it is vitally important to the health of the citizens of the State of Michigan that the medical profession see that all possible safeguards for their health care be provided, and

Whereas, is is generally agreed that the Michigan State Medical Society is the medical organization with whom such responsibility should rest, and

Whereas, it is agreed that the Michigan State Medical Society has the further responsibility of protecting the interests of medical doctors practicing in Michigan, and

Whereas, the Oakland County Medical Society, on behalf of all physicians in the State of Michigan, feels that in situations in which a medical doctor has been convicted of a felony, even though he may not have been a bona fide member of the Michigan State Medical Society, it should be within the province of the MSMS Judicial Commission to investigate the facts of such a case and to make appropriate recommendations to the Michigan State Board of Registration in Medicine, therefore be it

RESOLVED: That the Michigan State Medical Society empower and instruct the MSMS Judicial Commission to investigate instances such as described above and to make such recommendations as may be necessary to the Michigan State Board of Registration in Medicine for the purpose of safeguarding both the citizens and the practicing doctors of Michigan.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of this resolution for the following reasons: 1) MSMS does not have basic authority or jurisdiction to investigate or make recommendations concerning a civil action against a member or nonmember of MSMS. 2) There are adequate mechanisms available for any citizen to make complaints or recommendations to the State Board of Registration in Medicine concerning physicians accused of a felony. 3) Committee recommends that MSMS inform the public via appropriate news media that this Society has no authority to grant or revoke medical licensure.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 9

Criminal Penalties for Violation of Administrative Rules

Introduced by D. Bonta Hiscoe, MD

Whereas, a revised Michigan Criminal Code will be submitted to the Michigan State Legislature for its consideration during the regular 1969 session of the Legislature, and

Whereas, the final draft of proposed new section 4235 of this new Michigan Criminal Code reads: "A person commits the crime of engaging in a business improperly if, after having once obtained a license, certificate, or permit required for the business, profession, or occupation in which he is engaged or practices, or while engaging in a business, profession, or occupation for which no license, certificate, or permit is required, he intentionally violates any statute or lawfully adopted rule or regulation governing or regulating that business, profession, or occupation. Engaging in a business improperly is a Class C misdemeanor", and

Whereas, this proposed language embodies a major substantive change in that it would classify as a crime, and impose criminal penalties for, the violation of a bureaucratic rule, since criminal penalties have historically only been levied for violation of laws adopted by the elected representatives of the people, and

Whereas, this proposed new major change would establish precedent, and although a "Class C misdemeanor" carries with it upon conviction a maximum fine of $250 and/or a maximum sentence of imprisonment for 30 days, once the violation of a rule adopted by a State agency is established to be a criminal offense the "class" of misdemeanor could be altered, and

Whereas, the traditional penalties for intentional violation of either a statute or a rule regulating a profession have been determined by the appropriate licensing and regulating board, and adequately police the profession and protect the public through power to suspend or revoke licenses, but this proposed new Criminal Code section would make it a criminal offense not only to violate any rule adopted by the licensing authority, but to violate a rule promulgated by any State agency administering programs involving the profession, therefore be it

RESOLVED: That this House of Delegates opposes the making a crime of violation of a rule or regulation adopted by an agency of State government, and be it further

RESOLVED: That this House of Delegates specifically opposes the inclusion of proposed Section 4235 of the revised Michigan Criminal Code, and be it further

RESOLVED: That copies of this resolution be forwarded to all appropriate parties and the Michigan State Medical Society take all further necessary steps to implement the intent of these resolveds.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 10

Pilot Study to Improve Hospital Efficiency

Introduced by Edward J. Tallant, MD

Whereas, the present shortage of physicians is likely to continue into the foreseeable future, and

Whereas, this shortage is of great concern not only to the medical profession, but also to the general public and the Federal government, and

Whereas, despite vigorous efforts to expand the facilities to train more medical students, it is projected that the serious shortage will continue because of our expanding population, and

Whereas, an alternative answer to the problem is to utilize more efficiently the time of practicing physicians, and

Whereas, a major part of modern medical practice is centered in the hospital, where, as everyone knows, there is a great need for streamlining procedures which could make medical care, and the physicians' labors much more efficient, therefore be it

RESOLVED: That The Council of MSMS be instructed to seek a grant for the purpose of conducting a meaningful pilot study on ways and means to make it possible to conserve the time and energy of the medical staff in the care and treatment of patients; to devise new and imaginative methods to reduce the number of personnel required to service patient hospital care; and to investigate and project into the future the use of various automation devices in hospitals that would improve the efficiency, reduce the cost and save on labor in the hospital care of patients.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, deleted the word "automation" from the Resolved and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 11

Seating of Delegates at Special Sessions

Introduced by C. Jackson France, MD

Whereas, questions arose as to who were eligible to be seated at the Special Session of the House of Delegates of the Michigan State Medical Society, held in February 1968, and

Whereas, the Bylaws do not specify whether an alternate delegate seated at the Annual Session of the House of Delegates serves for that session only or whether he assumes the office of delegate until the end of the year, therefore be it

RESOLVED: That the Bylaws Committee of the Michigan State Medical Society submit an amendment to clarify this problem.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate Bylaws changes to amend Chap. 9, Sec. 4, adding the words "and remains a Delegate until the next Annual Session" to the end of the first Sec. 4 sentence.

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 12

Membership Requirements

Introduced by Homer M. Smathers, MD

Whereas, Chapter 2, Section 1 of the Michigan State Medical Society Bylaws requires, "To be eligible for active membership in any component county society, a doctor of medicine must hold an unrevoked license to practice medicine, surgery, and mid-wifery in Michigan," and

Whereas, the word "mid-wifery" is archaic and demeaning to the practice of medicine today, therefore be it

RESOLVED: That the word "mid-wifery" be deleted from Chapter 2, Section 1 of the Bylaws.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate Bylaws changes, amending Chapter 2, Section 1, by deleting from the second sentence the words "to practice medicine, surgery and mid-wifery."

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 13

Exemption of Dues for Hardship Cases

Introduced by Paul R. Dumke, MD

Whereas, each year there are members who are unable to pay their dues because of illness or financial reasons, and

Whereas, many of these physicians are ineligible for Associate Membership and remission of dues, and

Whereas, temporary assistance will enable such physicians to maintain their membership, and

Whereas, the Board of Trustees of the American Medical Association may excuse members from payment of dues provided they are excused from payment of local dues by their component and state associations, therefore be it

RESOLVED: That Chapter 5 of the Michigan State Medical Society Bylaws be amended by addition of the following section:

"Section 8. Hardship Cases: A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness may be excused from payment of dues by The Council, provided the member is fully or partially exempted from the payment of local dues. A member may also be excused from payment of dues because of financial hardship for other reasons, but these must be set forth by the secretary of the member's component society."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented, on first reading, appropriate

Bylaws changes, adding to Chapter 5, a new Section 8 as follows: "Sec. 8. HARDSHIP CASES — A member for whom the payment of dues would be a financial hardship by reason of physical disability or illness may be excused, fully or partially, from payment of dues by The Council provided the member is fully or partially exempted from the payment of component society dues. A member may also be excused from payment of dues because of financial hardship, or for other reasons, but these must be set forth by the secretary of the member's component society."

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 14

Separate Sections on Neurology and Psychiatry

Introduced by Benjamin Jeffries, MD

Whereas, there is an increased number of neurologists in Michigan, and

Whereas, the neurologists are desirous of having their own section meetings, therefore be it

RESOLVED: That the Bylaws of the Michigan State Medical Society be amended to establish separate Sections for Neurology and Psychiatry.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended approval of the resolution and presented on first reading, appropriate Bylaw changes.

THE HOUSE, at its next meeting, adopted the report of the Reference Committee.

RESOLUTION 15

Uniform National Licensure Examination

Introduced by Luther R. Leader, MD

Whereas, it is archaic that physicians licensed to practice medicine in one state find because of technicalities in the laws of another state they cannot obtain reciprocity and must take the examination of the other state to qualify to practice, and

Whereas, the Federation of the State Medical Boards has attempted to devise a uniform national licensing examination which would be acceptable in all states of the Union, and

Whereas, such a uniform national licensing examination is most desirable and should be adopted without delay, and

Whereas, the Michigan State Board of Registration in Medicine accepts the National Board examination as adequate qualification for licensure, and

Whereas, the Michigan State Board of Medical Examiners in the Basic Sciences does not recognize the National Board examination, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, go on record as favoring and strongly urging the adoption by all states of a uniform national licensing examination, and be it further

RESOLVED: That the Michigan State Board of Medical Examiners in the Basic Sciences accept the National Board examination, seeking whatever changes in the present Michigan law as may be necessary to achieve that end, and be it further

RESOLVED: That the Michigan Delegates to the American Medical Association be instructed to present at the next meeting of the House of Delegates of the American Medical Association a similar resolution in support of a uniform national licensing examination, and be it further

RESOLVED: That a copy of this resolution be sent to the Michigan State Board of Registration in Michigan, the Michigan State Board of Medical Examiners in the Basic Sciences, and the President of the Federation of State Medical Boards.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, deleted the fourth and fifth Whereas and the second Resolved, and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 16

Procedures for Resolving Grievances Against Non-members

Introduced by Laurel S. Eno, MD

Whereas, the county medical society can accept and investigate complaints only against physicians who are members, and

Whereas, there are no facilities available to patients who have grievances against physicians who are not members of the local medical society, and

Whereas, patients of non-member physicians should be protected against unethical practices, and

Whereas, the services, fees and conduct of physicians who are not members should be subject to the same standard of behavior as are members of the Michigan State Medical Society, and

Whereas, under present circumstances Michigan State Medical Society members are subject to criticism for behavior of non-members and have no provision for entering into the review of the activities of such non-members, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society appoint a committee to investigate the problem of grievances against non-member physicians and to recommend methods by which it may be solved.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, changed the Resolved portion to read:

"RESOLVED: That the Legal Affairs Committee be instructed to investigate the problems of grievances against any physician licensed to practice medicine in the State of Michigan and to recommend methods by which they may be resolved."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 17

Educational Program on Professional Legal Responsibility

Introduced by Raymond J. Barrett, MD

Whereas, members of the legal profession who defend the majority of malpractice claims against physicians are unanimous in their opinion that an intensive educational program is necessary to inform physicians and ancillary medical personnel of the legal pitfalls which often lead to suits of malpractice, therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, urges all component county medical societies, as well as the medical staffs of all the larger hospitals in Michigan, to devote at least one meeting annually to a discussion of the legal problems of medical care by an attorney competent in the field of malpractice, and be it further

RESOLVED: That the medical staff of every hospital in Michigan be urged to inform all ancillary medical personnel who are concerned with patient care, not to discuss with, or in the presence of, the patient any matters concerned with the patient's diagnosis, treatment or care or the qualifications of any physician on the medical staff.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended approval of the resolution amended to read as follows:

Whereas, members of the legal profession who defend the majority of claims against physicians are unanimous in their opinion that an intensive educational program is necessary to inform physicians and ancillary medical person-

nel of the legal pitfalls involved in patient care which lead to lawsuits; therefore, be it

RESOLVED: That the House of Delegates of MSMS urge all component medical societies as well as the medical staffs of the hospitals in Michigan to devote at least one meeting annually to a discussion by an attorney or other persons competent in the field of legal problems of medical care; and be it further

RESOLVED: That the administrative staff of every hospital in Michigan be urged to inform all ancillary medical personnel who are concerned with patient care not to discuss with, or in the presence of, the patient any matters concerned with the patient's diagnosis, treatment, or care or the qualifications of any physician or nurse on the staff."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 18

Medical Staff Tenure

Introduced by A. H. Hirschfeld, MD

Whereas, the present method of hospital staff appointments which are renewable on a yearly basis can be used by the hospital board of trustees and/or hospital administrators to discourage open and frank discussion and criticism of hospital administration by members of the medical staff, and

Whereas, such open and frank discussion by members of the medical staff is to the best interest of patient care, therefore be it

RESOLVED: That the MSMS House of Delegates favor indefinite tenure of appointment to the medical staff of all hospitals in Michigan after an appropriate probationary period of appointment with termination of appointment to the medical staff subject only to conviction of a felony, revocation of license by the State, conviction of unethical practice by a county medical society or the Michigan State Medical Society, or violation of the bylaws, rules or regulations of the hospital which has been approved by the medical staff, and be it further

RESOLVED: That this resolution be sent to the president of each board of trustees and the president or chief of staff of each medical hospital in Michigan.

THE REFERENCE COMMITTEE on Miscellaneous Business, M. Peebles Meyers, MD, Chairman, recommended approval of the resolution after amending the first Resolved to read:

"RESOLVED: That the MSMS House of Delegates favor annual reappointment to the active medical staff; that reappointment shall not be denied except for medical ineptitude, character deficiency, or conviction of unethical conduct."

THE HOUSE added an additional phrase to the first Resolved in the Reference Committee report and adopted the report as amended. The amended first Resolved read:

"RESOLVED: That the MSMS House of Delegates favor annual reappointment to the active medical staff; that reappointment shall not be denied except for medical ineptitude, character deficiency, or conviction of unethical conduct, revocation of license by the State, or violation of the Bylaws, rules or regulations of the hospital which have been approved by the medical staff."

RESOLUTION 19

Establishment of a Legal Section in Michigan Medicine

Introduced by Arthur B. Levant, MD

Whereas, many legal matters of concern to the members of Michigan State Medical Society escape their notice for lack of publicity, therefore be it

RESOLVED: That *Michigan Medicine* establish a medical-legal section to be published at least six times a year with timely articles prepared by attorneys who specialize in legal medicine.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended no official action on the resolution since the Publication Committee had indicated its commitment to this end in 1969.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 20

Binding Arbitration in Malpractice Suits

Introduced by John G. Slevin, MD

Whereas, the Professional Liability Committee of MSMS has studied the various arbitration panels, such as the Pima County Plan, whereby defendant physician and plaintiff submit their case to a joint committee of lawyers and physicians to determine the validity of the malpractice claim, and

Whereas, the Professional Liability Committee has found none of these plans is satisfactory because arbitration is not binding on either party, therefore be it

RESOLVED: That the House of Delegates, request the Joint Committee of the Michigan Bar and MSMS, which is now in the process of studying the problem of malpractice to include in its report, due in September 1969, a factual analysis and its recommendations concerning legality, practicability and advisability of establishment by law of a method whereby, if both parties to a malpractice suit voluntarily agree to abide by binding arbitration, it could minimize the number of such suits, lessen the burden of cost, render justice to both parties, hasten settlement, and leave to the courts only the question of the amount of damages if the arbitration board finds in behalf of the plaintiff.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended approval of the Resolution with the following substitute Resolved:

"RESOLVED: That the House of Delegates request the MSMS Liaison Committee with the State Bar to include in its report, due in September, 1969, its recommendations concerning the legality and advisability of establishment by law of a method of binding arbitration in malpractice suits."

THE HOUSE amended the substitute Resolved by adding after the words "binding arbitration" the following: "voluntarily agreed to by both parties", and adopted the report of the Reference Committee as amended.

RESOLUTION 21

Water Pollution

Introduced by William Haeck, MD

Whereas, water pollution is an increasingly urgent national problem directly related to a progressively complex industrial and urban society, and

Whereas, the Great Lakes area is a particularly important problem as exemplified by the accomplished decline in Lake Erie and the progressive crisis in Lakes Michigan and Huron and even Lake Superior, and

Whereas, constructive forces in the field of conservation, in government and in industry are opposing the problem of pollution despite many handicaps and opposite pressures, and

Whereas, the medical profession, in its concern for ecology and the *total* environment of modern man, must sustain a resolute continued interest in water pollution as an important cause of bacterial, viral and toxic chemical disease, and

Whereas, pure and abundant water in this area of Great Lakes beauty is an aesthetic necessity for residents and visitors in this era of the longer vacation and the shorter work week, therefore be it

RESOLVED: That a standing committee of MSMS be created to be concerned with water pollution and that shall function with an authoritative and dynamic voice in support of organizations, public and private that are engaged in the war against pollution.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution with the deletion of the words in the Resolved "be created to."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 22

Out-patient Physical Therapy Treatments

Introduced by Frederick S. Gillett, MD

Whereas, there has long been a shortage of adequate physical therapy facilities in most communities in the State of Michigan and likely this will continue for a long time to come, and

Whereas, many hospital physical therapy departments are unable to furnish adequate out-patient physical therapy treatments because of the heavy in-patient demands, and

Whereas, there are many Registered Physical Therapists in private practice who are well equipped to treat patients under the prescription of a Doctor of Medicine or Doctor of Osteopathy, and

Whereas, many insurance companies, including Michigan Blue Cross, now insist that all out-patient physical therapy treatments must be given in a hospital physical therapy department, therefore be it

RESOLVED: That The Council seek the enactment of legislation requiring insurance companies to provide in their policies, giving physical therapy benefits, that these treatments may be provided on an out-patient basis by any Registered Physical Therapist, under the direct specific orders of a Doctor of Medicine or a Doctor of Osteopathy.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended the approval of the Resolution with the substitution of the following Resolved:

"RESOLVED: That The Council request the Health Insurance Council to seek a solution to the problem of providing out-patient physiotherapy by a licensed physiotherapist under the direct specific orders of a Doctor of Medicine or Osteopathy."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 23

Referendum

Introduced by Harvey M. Andre, MD

Whereas, American democratic organization has always been designed to allow the will of the majority of individual members of any organization to determine that organization's policy, and

Whereas, traditionally the total membership of any organization has had the right of referendum concerning any action taken by its duly elected representatives, and

Whereas, the MSMS has traditionally been a democratic organization representing all of the member doctors of medicine in this State, therefore be it

RESOLVED: That Chapter Fifteen of the Bylaws be amended by the addition of Section Three to read: "Disapproval of any action of the House of Delegates may be accomplished by a direct mail polling of the entire membership of the Michigan State Medical Society upon petition signed by no less than three hundred members in good standing. A majority vote of the entire voting membership disapproving of any action of the House of Delegates shall be final and binding."

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution and that the question of referendum by petition including the use of mail ballots be studied by the Standing Committee on Constitution and Bylaws for recommendations to the next House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 24

Publication and Distribution of Minutes of The Council of MSMS

Introduced by Bruce D. Bauer, MD

Whereas, Delegates to MSMS should be well informed of actions of The Council prior to the annual session, and

Whereas, The Council considers matters of considerable import necessary for the proper function of MSMS, and

Whereas, is is the obligation of The Council to render a report to the House of Delegates on matters germane to the Society, and

Whereas, minutes of The Council must be approved, transcribed, then re-evaluated by the Executive Committee, therefore be it

RESOLVED: That the minutes of The Council, after each meeting, be made available to the Delegates prior to their approval by said Council, and be it further

RESOLVED: That these said minutes of The Council be in printed form, labeled confidential, and distributed to the House of Delegates members.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended disapproval of the resolution believing that the intent could be achieved better through closer communication between Councilors and component societies.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 25

Improvement of Ambulance Services

Introduced by Edward E. Elder, Jr., MD

Whereas, a primary contact between the medical care system and patients is the ambulance service, and

Whereas, the medical profession is in a position to help train ambulance personnel, and

Whereas, patients' lives may actually be saved by proper first aid at the scene of accidents or in the ambulances on the way to a hospital, therefore be it

RESOLVED: That this House of Delegates urge the Michigan State Medical Society and each component medical society to take an active interest in training ambulance personnel and in upgrading ambulance service.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 26

Four-Year Medical School at MSU

Introduced by Robert M. Stow, MD

Whereas, the Michigan State Medical Society has, for several consecutive years, through its House of Delegates and Council and in all other practicable ways, strongly urged the expansion of the two-year medical school at Michigan State University to a four-year school, and

Whereas, through the development of the clinical areas of the MSU medical school curriculum, the State of Michigan can most immediately, effectively and economically qualify Michigan State University's present program as a Class A medical school, thus with speed and efficiency increasing the supply of well trained physicians so greatly needed to meet the health needs of our rapidly growing population, and

Whereas, meeting the demand for properly trained physicians is everybody's business; this State Medical Society has long urged, and will continue to urge, that our state move with all possible speed to bring its medical education facilities at the University of Michigan, Wayne State University, and Michigan State University, to full function; lay groups should be established which would take it upon themselves to join MSMS in urging the necessary legislative financial support to bring about this result, therefore be it

RESOLVED: That this House of Delegates once more respectfully urge the Governor and State Legislature of Michigan to proceed with the expansion of the two-year College of Human Medicine to a complete college of medicine at MSU granting the degree of Doctor of Medicine, and be it further

RESOLVED: That The Council of MSMS take immediate steps to develop a group of lay leaders in the State of Michigan who can and will effectively join with us in urging the logical development of the MSU medical education program.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered together Resolutions 26 and 27 and in lieu thereof, submitted the following Substitute Resolution and recommended its approval.

SUBSTITUTE RESOLUTION

The Expansion to a 4-Year Medical School at Michigan State University and its Funding

Whereas, the Michigan State Medical Society has for several consecutive years, through its House of Delegates and Council and in all other practicable ways, strongly urged the expansion of the two-year medical school at Michigan State University to a four-year school, and

Whereas, through the development of the clinical areas of the MSU medical school curriculum the State of Michigan can most immediately, effectively and economically qualify Michigan State University's present program as a fully accredited medical school, thus with speed and efficiency increasing the supply of well-trained physicians so greatly needed to meet the health needs of our rapidly growing population, and

Whereas, meeting the demand for properly trained physicians is everybody's business; this State Medical Society has long urged, and will continue to urge, that our state move with all possible speed to bring its medical education facilities at the University of Michigan, Wayne State University and Michigan State University to full function; lay groups should be established which would take it upon themselves to join MSMS in urging the necessary legislative financial support to bring about this result; therefore be it

RESOLVED: That this House of Delegates once more respectfully urge the Governor and State Legislature of Michigan to proceed with the expansion of the two-year College of Human Medicine to a complete college of medicine at MSU granting the degree of Doctor of Medicine; and be it further

RESOLVED: That the Michigan Legislature be strongly urged to make the required appropriation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 27

Appropriation of Funds for MSU Four-Year Medical School

Introduced by C. Allen Payne, MD

Whereas, MSU's two-year College of Human Medicine has been in operation for two years, and

Whereas, the MSU College of Human Medicine is proving its capacity to recruit faculty of excellence and dedicated to new and community-oriented educational efforts, and

Whereas, the Citizens Committee for Education for Health Care, of the State Board of Education, in 1966 studied Michigan's manpower needs and MSU's capability to became a complete four-year medical school, and

Whereas, the Citizens Committee's recommendation to the State Board of Education was that MSU be authorized to develop a complete four-year medical school, and

Whereas, the State Board of Education, in January, 1967, did act favorably on the Citizens Committee report, and recommended a four-year medical school at MSU, and

Whereas, current surveys of Michigan physicians and hospital administrators, carried out by the Michigan Health Council, indicate that the medical manpower crisis deepens steadily, and

Whereas, the Michigan Legislature has not yet authorized or funded expansion of the MSU College of Human Medicine to a complete four-year school, therefore be it

RESOLVED: That the attention of the Honorable George Romney, Governor of Michigan, be called to this situation, and that he be strongly urged to recommend the appropriation of funds required to begin expansion of Michigan State University's two-year College of Human Medicine to a full four-year medical school during the fiscal year 1969-1970, and be it further

RESOLVED: That the Michigan Legislature likewise be strongly urged to make the required appropriation.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered together Resolutions 26 and 27 and, in lieu thereof, submitted a substitute resolution (see Resolution 26).

RESOLUTION 28

Disability Compensation

Introduced by Noyes L. Avery, MD

Whereas, employee compensation for disability and injury are an increasing problem for the disabled, medical, employer and insurance groups, and

Whereas, real disability problems exist as a result of disease or injury arising out of special conditions of employment, but also disability occurs during, before, or after employment activity which is not or only remotely related to conditions of employment, and

Whereas, there is an increasing tendency for the courts to grant employer compensation for conditions not truly considered related to employment from purely medical, and scientific reasoning, and

Whereas, this type of court action has been influenced by the misfortune of the disabled, and the resulting sympathy and the lack of other means of support and recompense of such disabled persons, and

Whereas, these decisions have often rested on medically meaningless, prostituted or confusing medical testimony and often have been in conflict with factual and responsible medical testimony, and

Whereas, compensation insurance premiums have increased at an inordinate and unfair rate when actual causative factors are considered, and

Whereas, there has been decreasing reliance on credibility of responsible medical testimony by the courts in the matter of causations in cases of employment disability, and

Whereas, the disabled are none-the-less disabled whether or not the disability was caused by or resulted from or aggravated by conditions of employment, therefore be it

RESOLVED: That MSMS, jurists, lawyers, laborers, employers, and insurance carriers cooperate to create more reasonable concepts of disability compensation, and be it further

RESOLVED: That consideration be given to compensation for disability whether or not it be related to special conditions of employment, and be it further

RESOLVED: That MSMS take the initiative in forming a proper commission which will search for a proper solution to this problem and make recommendations toward these ends.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution feeling this was primarily a matter of legal and socio-economic importance and not entirely within the province of the MSMS.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 29

Regional Advisory Committees to Blue Shield

Introduced by W. Kaye Locklin, MD

Whereas, in the past Michigan Blue Shield has had the benefit of the services of five county medical advisory committees to assist in the interpretation of difficult claims and in the adjudication of fees, and

Whereas, these county committees have served only a portion of the state, and

Whereas, there are some component societies without such committees, and

Whereas, there is need for a uniform appeal mechanism throughout the state for the physician in fee disputes with Blue Shield, and

Whereas, there will be a need for local physician involvement in review of utilization of professional medical services and charge patterns, and

Whereas, establishment of committees on a regional basis would make for increased efficiency, therefore be it

RESOLVED: That the MSMS recommend the formation of regional committees representative of the medical profession and selected by the component medical societies within each designated region to assist and advise Michigan Blue Shield in the review of claims, the arbitration of fee disputes, and review of utilization frequency and charge patterns.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, amended the Resolved by deleting "designated regions" and inserting "Councilor Districts or combination thereof" and recommended approval of the resolution as amended.

THE HOUSE further amended the Resolved, adding "that the physician representatives on the regional committees will report back to their component medical societies." and adopted the report of the Reference Committee as amended.

RESOLUTION 30

State and County Society Membership for Residents

Introduced by Edward E. Elder, Jr., MD

Whereas, recently the AMA suggested that means be found by which interns and residents could take a more active role in the local and state medical societies, and

Whereas, the Bylaws of the MSMS state that any licensed physician is eligible for active membership in the MSMS and the local societies, and

Whereas, residents are licensed physicians, and

Whereas, many of the decisions made by the local societies and the MSMS will directly affect the interns and the residents when they enter private practice, and

Whereas, the local societies and the MSMS are forums for the expression of new ideas and these new physicians would be another source of ideas and opinions, and

Whereas, many interns and residents may be interested in participating more actively in their local and state societies but are unable to because they cannot afford the dues necessary for active membership, therefore be it

RESOLVED: That the MSMS and the local societies institute a program whereby residents who are in residency programs within the State of Michigan and who hold a permanent Michigan license may become active members with all the rights and privileges thereof of the local society and the MSMS, and be it further

RESOLVED: That dues be at the discretion of the local society but that they be not more than 10 per cent of the dues charged a practicing physician member.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended no action on this resolution since the MSMS Bylaws already provide for full membership for any licensed physician and the resident may become an associate member with no dues if he so wishes.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 31

Protection by Law of Committees of Medical Societies

Introduced by Francis P. Rhoades, MD

Whereas, Public Act. No. 270 of 1967 protects physicians and hospitals from liability for release of medical information to any in-hospital staff committee, used in the course of study for the purpose of reducing morbidity or mortality or to advance medical research and education; and

Whereas, the county medical societies, the State Medical Society and medical specialty societies also have committees to whom medical information is released for the purpose of reducing morbidity or mortality or to promote medical education and research; therefore be it

RESOLVED: That the House of Delegates urges an amendment to Public Act 270 of 1967 to extend the benefits and protection of this law to similar committees of county medical societies, the MSMS and the medical specialty societies.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 32

Compensation for Regional Anesthesia

Introduced by S. N. Kelso, Jr., MD

Whereas, many general practioners and obstetricians have of necessity been administering saddle block or other regional anesthesia in patients for delivery, and

Whereas, malpractice insurance for anyone performing these procedures has recently taken a dramatic rise, and

Whereas, there are many hospitals in the state where anesthesiologists are not available to administer regional anesthesia, i.e. (saddle block or caudal), therefore be it

RESOLVED: That when regional anesthesia is administered by the attending obstetrician, it be a a compensable benefit in all Blue Shield programs.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the following Substitute Resolution:

"Whereas, many attending physicians have of necessity been administering regional anesthesia; therefore be it

"RESOLVED: That Michigan Medical Service be requested to study the feasibility of making regional anesthesia administered by the attending physician a compensable benefit in all Blue Shield programs."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 33

Minor's Consent to Venereal Disease Therapy

Introduced by Eli J. Igna, MD

Whereas, many minors do not seek treatment for venereal disease because they know their parents must be notified to gain consent for treatment; and

Whereas, the highest incidence of venereal disease is in the "under 21" age group; and

Whereas, late treatment results in less cures and more dissemination of venereal disease; therefore be it

RESOLVED: That The Council direct its Legislative Committee to urge the State Legislature to pass a law allowing minors to give their own consent for examination for and treatment of venereal disease.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 34

Use of Computer Techniques by the Board of Registration in Medicine

Introduced by Alexander Blain, III, MD

Whereas, some 600 doctors of medicine are examined each year for a license to practice in Michigan, and

Whereas, the preparation of the examinations requires about 300 hours work by each member of the Board, and

Whereas, the number of eligible applicants will increase by about 25% with the expansion of the Wayne State University School of Medicine and the operation of the Michigan State University School of Human Medicine as a four year school, and

Whereas, there is an increasing demand for the examination of individuals and small groups at various times between regular examinations given in January and June, and

Whereas, this increasing work load requires the use of improved and advanced techniques to render acceptable service, therefore be it

RESOLVED: That the MSMS does hereby recommend that the Board of Registration in Medicine explore all possibilities and adopt such modern and advanced techniques as, in its opinion, may best serve to expedite its lawful function of examination, licensure and regulation of the practice of medicine in Michigan, and be it further

RESOLVED: That an adequate fee, commensurate with the cost, be charged for such service.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 35

Deletion of the American Medical Association Reinstatement Fee

Introduced by Brock E. Brush, MD

Whereas, Chapter III, Section 1 (E), of the Bylaws of the American Medical Association states: "Members of the American Medical Association who have been dropped from the membership roll for non-payment of annual dues cannot be reinstated until such indebtedness has been discharged, and such indebtedness shall apply only to the one year of delinquency;" and

Whereas, the payment of this reinstatement fee of one year's dues plus current dues to the American Medical Association (a total of $150 in 1968) may be a financial hardship to the physician and deterrent to the reinstatement of his membership; and

Whereas, the physicians may be members of their local medical society and MSMS without membership in AMA, and

Whereas, members of component medical societies should be encouraged to be members of the American Medical Association; therefore be it

RESOLVED: That the Michigan Delegates to the AMA be instructed to introduce at the 1968 Interim Meeting an appropriate resolution to delete the membership reinstatement fees as specified in Chapter III, Section 1 (E) of its Bylaws.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 36

Physicians' Hospital Privilege Act

Introduced by Leon Rottenberg, MD

Whereas, The MSMS House of Delegates has passed 1966 Resolution 55 — Hospital Staff Privileges for All Ethical Licensed Physicians; and

Whereas, the AMA House of Delegates unanimously passed 1966 Resolution 34 that "all doctors of medicine regardless of their field of practice be accorded hospital privileges commensurate with their training, experience, and demonstrated competence; and that in the public and professional interest every ethical licensed doctor of medicine who needs and desires them have staff privileges in at least one accredited, full facility community hospital,"; and

Whereas, the MSMS House of Delegates in 1967 instructed the Legal Affairs Committee to study the feasibility of developing a Physician's Hospital Privilege Act; therefore be it

RESOLVED: That this House of Delegates recommend that an ad hoc committee of the House be appointed to study the Physicians' Hospital Privilege Act and report back to the 1969 House.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended no action on the resolution since this subject is under active consideration by the Legal Affairs Committee.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 37

Establishment of Committees to Evaluate Hospital Provided Care

Introduced by Loyal W. Jodar, MD

Whereas, claims are constantly being made as to the advanced level of medical care now available; and

Whereas, hospitals and their boards have appointed numerous committees to check on the quality of professional care rendered by medical staff members; and

Whereas, at present complaints and suggestions of individual physicians regarding inadequacies of hospital provided care receive insufficient attention; and

Whereas, the Joint Commission on Accreditation of Hospitals requires establishment of various committees to evaluate professional patient care; therefore be it

RESOLVED: That MSMS recommend to the Joint Commission on Accreditation of Hospitals that they require formation of Hospital Care Committees in all approved hospitals, composed of physician members of the staff, to review all aspects of hospital provided patient care.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, suggested the following changes in the third Whereas, to read: "Whereas, at the present time complaints and suggestions of physicians regarding a hospital's failure to provide care of an acceptable professional standard receives insufficient attention from Administration", and delete the fourth Whereas and revise the Resolved to read:

"That the House of Delegates authorize The Council to appoint a committee to investigate such complaints when

petitioned by a majority of the active staff of an accredited hospital and to make appropriate recommendations."

The Reference Committee then recommended the approval of the resolution as amended.

THE HOUSE did not adopt the report of the Reference Committee, but instead adopted the Resolution in its original form.

RESOLUTION 38

Practice Opportunities in Michigan

Introduced by Fred E. Caumartin, MD

Whereas, the MSMS House of Delegates has repeatedly urged the State Legislature to support the financial requests of the three medical schools in this State; and

Whereas, the people of Michigan are experiencing a serious shortage of private medical practitioners; and

Whereas, the hospitals of Michigan with educational programs are having increasing difficulties in obtaining physicians to fill their many house officer positions; therefore be it

RESOLVED: That the House of Delegates urge the deans of the three medical schools in Michigan to acquaint and urge the medical students in their various schools to consider seriously the advantages and the opportunities of the hospitals in this state and further to consider entering practice in the State of Michigan.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, changed the Resolved by inserting the words "and faculties" after the word "deans" and recommended approval of the resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 39

Blue Shield Advertising

Introduced by Thomas M. Flake, MD

Whereas, some of the Blue Shield advertising for its new Variable Fee Program has been confusing to both physicians and patients; and

Whereas, such confusion may result in errors, problems and criticism; and

Whereas, it is in the best interest of Michigan Medical Service, the doctors and the subscribers that these contracts be clearly understood by all; therefore be it

RESOLVED: That the House of Delegates urge the Board of Directors of Michigan Medical Service to review all advertising and public announcements prior to their release.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read: "That the House of Delegates urge the Board of Directors of Michigan Medical Service to carefully review advertising policy."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 40

Rescinding of Abortion Laws

Introduced by Henry A. Scovill, MD

Whereas, the current abortion laws of the State of Michigan are very restrictive so that only a very few women may receive legal abortions; and

Whereas, all data indicate that despite these laws many women do receive criminal abortions and in the process many times seriously endanger their physical and mental health, and

Whereas, most studies indicate that the average woman who receives an abortion is married and in all other ways a law-abiding citizen, and

Whereas, all of the current abortion law reform bills are limited in their scope so that only a very few women would have the right to obtain an abortion, and

Whereas, the right to bear a child should be primarily determined by the pregnant woman and her husband, and

Whereas, the abolishment of the abortion laws would not force anybody who had moral or religious misgivings into either having or performing an abortion, therefore be it

RESOLVED: That MSMS urge the Michigan Legislature to rescind the abortion laws wherein they apply to pregnancies of less than thirteen weeks gestation.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution with the following amendments: Elimination of the third Whereas, and changing the Resolved portion to read, "RESOLVED: That the Michigan State Medical Society urge the Michigan Legislature to so alter the abortion laws that the criminal code will not apply to abortions performed by a licensed medical or osteopathic physician in an accredited hospital licensed by the State."

THE HOUSE adopted the amended resolution, after further amending it by striking the word "pregnant" from the fifth Whereas, so that it reads: "Whereas, the right to bear a child should be primarily determined by the woman and her husband."

RESOLUTION 41

Study of Osteopathic Physician Training Programs

Introduced by Clifford W. Colwell, MD

Whereas, osteopathic physicians care for a significant percentage of the population of the state of Michigan, and

Whereas, pressures are building within and outside of the medical and osteopathic professions to make their integration and cooperation a logical reality, and

Whereas, if this integration is to be accomplished, there must first be found a sound and equal basis upon which to judge and compare the background, training and competence of each of the two professions, and

Whereas, reports available at this time indicate that the training and experience offered at osteopathic medical colleges do not meet the minimum requirements for accreditation ordinarily applied to medical schools in the United States, and

Whereas, there is now no known good, available data on the training and experience offered in osteopathic internships and residencies, and

Whereas, Michigan has more osteopathic physicians than any other state in the Union, therefore be it

RESOLVED: That MSMS sponsor a study to provide information and evaluation concerning the current training of osteopathic physicians in their various schools and in their internship and residency training programs, and be it further

RESOLVED: That a special committee be appointed to implement this type of study promptly.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended that this resolution be referred to The Council for consideration.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 42

Registered Nurses

Introduced by Clifford W. Colwell, MD

Whereas, the ever-increasing population is placing more and more demand upon the medical and paramedical profession, and

Whereas, technological advances in the medical field require highly trained paramedical personnel, and

Whereas, refinements in patient care as well require highly trained and skilled paramedical personnel, therefore be it

RESOLVED: That MSMS encourage, foster and promote the training of registered nurses and the programs therefore, and be it further

RESOLVED: That MSMS ought to preserve and elevate the training of registered nurses and the programs therefore, and be it further

RESOLVED: That MSMS actively, through its staff, Council, and House of Delegates, discourage legislation that would in any way degrade the profession and dignity of a registered nurse or in any way equate the status of a registered nurse with persons of less training.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 43

Balanced Patient Concept for Nursing Homes

Introduced by Alfred Golden, MD

Whereas, all general hospitals are operated on the balanced patient load concept; the strictly intensive-care type of hospital is not economical or feasible; and

Whereas, modern nursing homes have been constructed and organized on the balanced load concept; and

Whereas, experience has shown that this principle results in the lowest possible per diem cost for the patient and the community; and

Whereas, the principle of separating the basic nursing home from the skilled nursing home will result in a downgrading of staff for the care of patients and also result in the undesirable frequent transfer of patients between facilities; therefore be it

RESOLVED: That the House of Delegates approve the principle of the balanced patient load concept for nursing homes; and be it further

RESOLVED: That the House of Delegates call this to the attention of the State Health Commissioner and the new committee appointed by the Governor to study nursing homes and their rates.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 44

Revision of Blue Shield Method of Payment to Physicians

Introduced by Sidney E. Chapin, MD

Whereas, the present profile method of determining fees only substitutes a range of fees for a set fee schedule; and

Whereas, in many areas in the country Blue Shield plans have found that complying with the individual physician's billing; without a fee schedule or arbitrary screening, has proved economical, equitable and predictable; and

Whereas, all county medical societies have an established procedure for arbitration of unfair fees; therefore be it

RESOLVED: That the House of Delegates recommend to Michigan Medical Service that it amend its present methods of payment to physicians, and adopt a method of payment based on the individual physician's billing, for group subscribers, individual subscribers and those supported by the Medicare-Medicaid program.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE did not adopt the Reference Committee report, but directed the Speaker to refer the resolution to a committee for further study.

RESOLUTION 45

Medical Aspects of Crime

Introduced by Ralph H. Pino, MD

Whereas, three years ago the Wayne County, Michigan State and the American Medical Association House of Delegates voted in favor of an educational program to inform the public on the causes and consequences of crime and delinquency from the medical standpoint; and

Whereas, little has been done to implement this resolution; and

Whereas, crime in the street presently is of political importance in this country; therefore be it

RESOLVED: That the MSMS House of Delegates reaffirm the resolution presented to the AMA House of Delegates in 1966 which states "that the American Medical Association is urged to continue and expand its efforts in crime prevention by initiating educational programs for physicians and the public and by appropriate studies on the medical aspects of crime prevention;" and be it further

RESOLVED: That a copy of this resolution be sent to the President of the American Medical Association.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 46

Immunity from Subpoena of Records of Medical Society Committees

Introduced by Charles E. Darling, MD

Whereas, Act No. 17 of the Public Acts of 1968 (Michigan Hospital Licensing Law) provides in Section 12 (2) that records of hospital committees, in review functions, are confidential and shall not be available for court subpoena; and

Whereas, the various committees of the state and county medical societies of Michigan have review functions similar to those of hospital committees; therefore be it

RESOLVED: That The Council instruct the Legal Affairs Committee to prepare legislation to grant review committees of Michigan State Medical Society, the component county medical societies and medical specialty societies immunity from subpoena of records by the Courts of the State of Michigan and to seek introduction of such legislation in the 1969 Session of the Michigan State Legislature.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended disapproval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 47

Qualifications for "Life Member", Michigan State Medical Society

Introduced by W. Kaye Locklin, MD

Whereas, requirement of today's medical education is more demanding timewise, and

Whereas, doctors of medicine are spending more years in academic training before beginning the practice of medicine, and

Whereas, there is a trend to retirement at an earlier age, and

Whereas, to qualify for "Life Member" in MSMS, a doctor must have attained the age of 70 years or have been in practice for 50 years, therefore be it

RESOLVED: That Chapter 2, Section 6, paragraph (a) of the Bylaws be studied by the Reference Committee on Constitution and Bylaws for modification more in keeping with the needs of the times.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. France, MD, Chairman, recommended disapproval of the resolution and referral of the general subject of life membership to the Constitution and Bylaws Committee for study.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 48

Para-Medical Education Program

Introduced by W. Kaye Locklin, MD

Whereas, the Subcommittee on Para-Medical Education of the Education Liaison Committee has been involved for the past three years in the development of a program for the education of physicians' assistants, with significant progress, therefore be it

RESOLVED: That this Committee be commended for its diligent efforts and urged to expedite the completion of this worthwhile educational project.

THE REFERENCE COMMITTEE on Public and Professional Relations, P. T. Lahti, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read: "That this Committee be commended for its diligent efforts and urged to continue this worthwhile educational project."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 49

Division of Blue Cross/Blue Shield Premium

Introduced by Donald N. Sweeny, Jr., MD

Whereas, in 1959 (Resolution 30), the MSMS House of Delegates recommended that all premium notices of Blue Cross/Blue Shield be itemized so that the subscribers may know what percentage of their premiums are used to defray hospital costs and for remuneration to physicians; and

Whereas, Blue Cross/Blue Shield continues to bill jointly; and

Whereas, the increase in health costs emphasizes the need for this differentiation between hospital and physician charges; therefore be it

RESOLVED: That the House of Delegates recommend to the Board of Directors of Michigan Medical Service that it announce to its subscribers annually the percentage of the premium paid to Blue Cross and the percentage to Blue Shield.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 50

Commendation to Dr. Ralph Pino

Introduced by J. C. Danforth, Jr., MD

Whereas, Dr. Ralph Pino has served the Michigan State Medical Society as a delegate for 23 sessions during the last 35 years, and

Whereas, Dr. Pino is continuing to serve as a delegate to the Michigan State Medical Society; therefore be it

RESOLVED: That the House of Delegates highly commend Dr. Ralph Pino for his many contributions to the activities of the Michigan State Medical Society, to the medical profession, and to the public it serves.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 51

Adjudication of Medical Problems

Introduced by J. A. Witter, MD

Whereas, the county medical society has established mechanisms for the review and arbitration of any problem that cannot be settled directly by the physician and the patient, and

Whereas, the county medical society has the right to seek the cooperation of its members in mediating these problems and has the procedure for exacting discipline if indicated; and

Whereas, there is adequate protection of the rights of both the physician and the patient through the appeal procedures of the Michigan State Medical Society; therefore be it

RESOLVED: That the House of Delegates recommend to the Board of Directors of Blue Shield that matters relating to ethics, professional conduct, mediation and discipline of physicians be referred to the county medical society for adjudication.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended that the resolution be disapproved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 52

Liaison with SAMA and MSMS

Introduced by Marjorie P. Meyers, MD

Whereas, the Student American Medical Association (SAMA) chapters at the University of Michigan, Wayne State University and Michigan State University meaningfully represent well over 90% of all medical students, interns and residents at their respective schools, and

Whereas, SAMA is now devoted to Concern, Commitment and Action in many fields of crucial importance to American Medicine today as is the Michigan State Medical Society, and

Whereas, SAMA would greatly benefit from the advice and counsel derived from close association and liaison with MSMS, therefore be it

RESOLVED: That MSMS officially establish liaison with the SAMA chapters at the University of Michigan, Wayne State University and Michigan State University by providing an official delegate to each of these chapters' advisory boards, and be it further

RESOLVED: That MSMS continue its financial support of these SAMA chapters and their increasing scope of activities and concerns by increasing the annual MSMS contribution to these SAMA chapters from $300 to $500.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution after amending the first Resolved to read: "That MSMS officially establish liaison with the SAMA Chapters in all accredited schools."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 53

Liaison with Medical Students, Interns and Residents

Introduced by Stuart Gould, Jr., MD

Whereas, there exists a definite lack of communications between the medical societies at the local, state and national levels, and the medical students, interns and residents concerning the purpose, operation and activities of the medical societies, and

Whereas, there exists no convenient way for medical students, interns and residents to obtain this information from the medical societies, and

Whereas, the establishment of better communications between the medical societies and the medical students, interns and residents will help to eliminate the lack of understanding between these groups, therefore be it

RESOLVED: That an official pamphlet be developed, published and distributed to all medical students, interns and residents concerning the purpose, operation and activities of the medical societies, and be it further

RESOLVED: That MSMS institute a program whereby medical students and interns may assume an affiliate membership with the local medical society in Michigan without all the rights and privileges of the local society, and be it further

RESOLVED: That a similar resolution be presented to the AMA House of Delegates by the delegates from MSMS at the earliest opportunity.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, approved the resolution in principle with the deletion of the first Resolved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 54

State Medical Examiner's Senate Bill

Introduced by Donald Finlayson, MD

Whereas, the State Medical Examiner's Bill (Senate Bill No. 479 of March 2, 1967), died in the State Legislature of Michigan this year, and

Whereas, the Senate Bill No. 479 wasn't adequate for implementation for proper services for people of the State of Michigan; and

Whereas, it has always been the responsibility and the custom of the medical profession to serve the people through its profession (as has well been demonstrated by the performance of practicing physicians in the past by their free services and time given to teaching hospitals, universities, and indigents), and

Whereas, the medical profession still recognizes its responsibility of service to the people, therefore be it

RESOLVED: That MSMS formulate, promote, and support a new Medical Examiner's Bill to replace the present Coroner's System for the entire State of Michigan, with equal protection under the law for all citizens of the State of Michigan irrespective of locality of residency, and be it further

RESOLVED: That such a bill consider pathologists as the obviously best qualified group of physicians to study, to be trained, and to take over the functions of the medical examiner, and be it further

RESOLVED: That pathologists who are employed and who are earning a proper living, and who would only serve as part-time medical examiners in the various counties of the State of Michigan be encouraged to offer their services to the State of Michigan without remuneration; that all such money procured from all such various counties (average annual Coroner's expense to various counties) be utilized to run the entire Medical Examiner's System to include an adequate increase in salaries for full-time medical examiners and toxicologists now in the state employment and now overworked and underpaid (as such a service would only be comparable to the time and free services rendered throughout the years to society by practicing physicians on the staff of teaching hospitals and universities), and be it further

RESOLVED: That MSMS work through proper channels for an adequate budget to run such a statewide Medical Examiner's System, thus made possible by the free services of pathologists, and be it further

RESOLVED: That state troopers of the Michigan State Police be used as assistants to the Medical Examiners; so that the state budget to run the Medical Examiner's System will be within reasonable reach through proper legislation. (It is to be recognized that it is the custom of state troopers to appear at the scene of such cases), and be it further

RESOLVED: That all efforts and skills of the MSMS be utilized to carry out these resolutions for the making of a new medical examiners bill for the protection of the people of the State of Michigan, with equal protection under the law for all citizens to seek and find the impartial truth, related to the certification of death affecting such cases involved with compensation, insurance, accidents, civil court suits, and criminal cases; all of which circumstances carry a tremendous impact upon our civil rights and protection and upon our entire massive national economy.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended that no action be taken on the resolution but that it be referred to The Council.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 55

Support for Michigan Variable Fee Program

Introduced by Robert M. Stow, MD

Whereas, the Michigan State Medical Society has, in previous years on three occasions, passed resolutions of commendation and/or endorsement of Michigan Blue Shield (i.e., Resolution 19 of 1944, Resolution IV-13 of 1945, and Resolution 56 of 1966); and

Whereas, MSMS approved the "Heidenreich-Bowman" Resolution in 1956 urging total participation of Michigan State Medical Society members in Michigan Blue Shield's plans, and

Whereas, there currently is no official indication of the State Society's support and endorsement of Michigan Blue Shield's Variable Fee Program, and

Whereas, the current Michigan Blue Shield Variable Fee (MVF) Program reflects essentially those known wishes of the Michigan State Medical Society and the medical profession in general concerning scope of benefits and payment mechanism (i.e., 1967 MSMS House of Delegates Resolutions Nos. 4, 5, 32, 36; and 1966 Resolution Nos. 16, 22, 26, 29, 35, 41 and 66); therefore be it

RESOLVED: That MSMS endorse the Michigan Variable Fee Program, both as to scope of benefits and payment mechanisms, and urge its membership to actively support the program in all aspects, and be it further

RESOLVED: That MSMS recommend that every physician member display to his patients and the community his own support and endorsement by formal participation in the MVF Program.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended adoption of the resolution with the following amendments:

Amend the first Resolved to read, "That MSMS endorse the Michigan Variable Fee Program, both as to scope of benefits and payment mechanisms, and urge its membership to actively support the program.

Delete the second Resolved.

THE HOUSE adopted the amended resolution after further amending the first Resolved to read: "That MSMS endorse the Michigan Variable Fee Program in principle."

RESOLUTION 56

Practice of Laboratory Medicine

Introduced by Frank B. Walker, MD

Whereas, the MSMS House of Delegates adopted Resolution 37 in 1965, stating that "the operation of a medical laboratory as defined represents the practice of medicine and that a medical laboratory should be supervised and directed by a licensed physician," and

Whereas, there is currently considerable lay, political, social, and corporate interest in medical laboratory activity, including the solicitation of specimens from physician's offices in Michigan, and

Whereas, such activty has been considered unethical by the AMA, the MSMS and various state and national specialty organizations, therefore be it

RESOLVED: that the 1968 House of Delegates reaffirm its 1965 action, and authorize The Council to take such steps as are necessary to implement its position, and be it further

RESOLVED: that a copy of this resolution be forwarded to the various state and national specialty societies, to the entire membership of the MSMS, and to the AMA.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended that the second Resolved be deleted, and that the resolution be adopted as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 57

Nursing Education

Introduced by Jack Hoogerhyde, MD

Whereas, the acute shortage of trained nursing personnel throughout the country has posed a serious problem in patient care in our hospitals, and

Whereas, the high standards for accreditation of hospital nursing schools, as demanded by the American Nursing Association, has increased costs of maintaining a nursing school and strained hospital budgets to new heights, and is reflected in higher hospital costs, which must be passed on to the patient, and

Whereas, many nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education, thus compounding the paucity of trained nurses, and

Whereas, the American Nursing Association would close all diploma, hospital-based nursing schools, transferring nursing education to the college campus, and

Whereas, experience has shown that graduates of two-year community colleges are not competent to assume responsibility on hospital wards without further supervision and training, and

Whereas, graduates of four-year baccalaureate programs in nursing theory may also require further supervision and training in responsible bedside nursing, and

Whereas, the emphasis on collegiate nursing education with the "phasing out" of all hospital nursing schools, can only result in a greater shortage of nurses, and

Whereas, recent legislation (H.R. 15757, the Manpower Training Act of 1968) has been passed by Congress, this act providing a subsidy to financially distressed nursing schools in the amount of $15,000 per year and is obviously intended to alleviate the stress on hospital finances and provide more trained nurses, and

Whereas, this important legislation is a step in the right direction, therefore be it

RESOLVED: That the Michigan State Medical Society:

1. Give its heartiest approval to H.R. 15757, and urge the legislative body of the American Medical Association to follow up and urge that subsidies to hospital nursing schools be further increased;

2. Voice its opposition to any plan to "phase out" hospital nursing schools;

3. Encourage the American Nursing Association to support four-year bacalaureate nursing training for only those applicants who possess the aptitude and desire to engage in nursing education.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered Resolutions 57 and 59 together and recommended the following Substitute Resolution, entitled "Nursing Education":

"Whereas, the acute shortage of trained nursing personnel throughout the country has posed a serious problem in patient care in our hospitals, and

"Whereas, many nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education, thus compounding the paucity of trained nurses, and

"Whereas, at the present time there is no unified academic program for training nursing personnel, and

"Whereas, the licensed practical nurse, the two-year associate degree nurse trained in our community colleges, the three-year diploma nurse trained in our hospital nursing schools, and the four-year baccalaureate university degree nurse are all separate entities and do not complement each other academically, and

"Whereas, recent legislation (H.R. 15757, the Manpower Training Act of 1968) has been passed by Congress, this Act providing a subsidy to financially distressed nursing schools, and is obviously intended to alleviate the stress on hospital finances and provide more trained nurses; therefore be it

"RESOLVED: That the Michigan State Medical Society:
1. Approve the intent of H.R. 15757 and encourage the House of Delegates of the American Medical Association to urge increased subsidies to hospital nursing schools.
2. Voice its opposition to ANY plan to "phase out" hospital nursing schools; and be it further

"RESOLVED: That the State Board of Education be requested to bring together all organizations concerned with nursing training to establish a unified academic program for all levels of nursing training aforementioned, and to establish a "master plan" whereby credits earned at each level of training be recognized and applicable to the next higher level of training; and be it further

"RESOLVED: That the State Board of Education consider integration of hospital nursing schools and community and state colleges in such a program."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 58

Prohibition of Cigarette Advertising on Television

Introduced by Fred C. Brace, MD

Whereas, television commercials are being beamed into our homes in ever-increasing volume, and

Whereas, children of ten spend many hours viewing this advertising on the television, and

Whereas, in a child's formative years he is very impressionable, and not able to evaluate which advertising is in his best interests, and

Whereas, cigarette advertising constitutes a sizeable percentage of the commercials seen via the television, and

Whereas, our medical profession recognizes the grave dangers in cigarette smoking, as the increase in lung cancer, cardiorespiratory illnesses, etc., as outlined by the United States Public Health Services, gives firm testimony, therefore be it

RESOLVED: That MSMS take the initiative in condemning all cigarette advertising on television, and be it further

RESOLVED: That this resolution be brought to the attention of the United States Public Health Services, the Department of Health, Education and Welfare, and to the legislative body of the American Medical Association, thus creating an awareness of this problem, and hopefully may initiate further action.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution after amending the Resolved portion to read:

"RESOLVED: That MSMS condemn all cigarette advertising on television, and be it further

"RESOLVED: That this resolution be brought to the attention of the United States Public Health Services, the Department of Health, Education and Welfare, and to the legislative body of the American Medical Association, thus creating an awareness of this problem, which hopefully may initiate further action."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 59

Nursing Education

Introduced by Victor Notier, MD

Whereas, there is a serious shortage of nursing personnel, nationwide and particularly in the State of Michigan, and

Whereas, degree bearing nurses are in particular shortage to staff school faculties, and

Whereas, an increasing number of potential applicants to schools of nursing desire a degree granting program, and

Whereas, such programs are of necessity, possible only in cooperation with, and as a part of a duly constituted college authorized to grant a Bachelor's degree, and

Whereas, to plan such new schools involves several years in preparation, therefore be it

RESOLVED: That the State Board of Education be enjoined to authorize such planning, and to officially accredit such schools, as part of the total academic program of such state colleges or universities, that at present do not have such schools, and who are so located that such schools could be developed, and be it further

RESOLVED: That the Legislature be appraised of the critical need in this area and enjoined to take appropriate steps legislatively to facilitate the earliest possible development of such schools as part of state colleges and universities where possible, and be it further

RESOLVED: That early attention be given to the critical needs in the Saginaw-Midland-Bay City area, with the Saginaw Valley College potential, and the Grand Rapids Metropolitan area with the Grand Valley College potential.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, considered Resolutions 57 and 59 together.

For Reference Committee and House action, see Resolution 57.

RESOLUTION 60

MDPAC

Introduced by Roy J. Gerard, MD

Whereas, MDPAC has functioned as an independent, autonomous organization with the full support of MSMS and its membership, and

Whereas, the need for more and continued political activity with its concomitant financial expenses and expenditures persists and expands, and

Whereas, the AMA and AMPAC, and each state medical society and its PAC have similar relationships and problems, therefore be it

RESOLVED: That The Council of MSMS appoint an ad hoc committee to study the relationships between the various state political action committees and the State Medical Society, and the relationship of the AMA and its PAC-AMPAC, and be it further

RESOLVED: That such an ad hoc committee present its findings and recommendations to The Council and to MDPAC.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution, after amending the first Resolved to read: "That The Council of MSMS appoint an ad hoc committee to study the relationships between the various state medical political action committees and their respective state medical societies, and the relationship of the AMA and AMPAC, and be it further . . ."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 61

Hospital Recertification Forms for Medicare and Medicaid

Introduced by R. J. Toteff, MD

Whereas, considerable time, effort, and money is now being expended by hospital, hospital personnel, and physicians to complete and correct hospital recertification forms for Medicare and Medicaid patients, and

Whereas, this is a "post hoc" type of procedure, since most of these patients have been discharged and accounts paid, and

Whereas, this bureaucratic excuse in boondoggling takes time and effort of medical, paramedical and secretarial personnel which would be more wisely spent in current needs on care, and

Whereas, this certification requires falsification of dates and other data which is immoral and dishonest, even if it is directed by government bureaucracy, and

Whereas, this "post hoc" certification is apparently a punitive bureaucratic exercise done under pressures toward the hospitals which has characteristics of blackmail, and

Whereas, the expense of this procedure causes an increase in cost of medical and hospital care, which is purely due to governmental bureaucracy, and for which the medical profession will be blamed, and

Whereas, by resistance and pressure, the initial certification form was discontinued, it indicates pressure can be successful, therefore be it

RESOLVED: That the House of Delegates of the MSMS recommend that all members of the Society be advised not to sign certification and recertification forms for hospitalization of Medicare and Medicaid patients after January 1, 1969 as already having been demonstrated as being unnecessary, and be it further

RESOLVED: That notification of this action be sent to the Michigan Hospital Service, Michigan Hospital Association, the Michigan State Social Service Board or Commission, The U.S. Social Security System, the AMA, and all other states societies, and be it further

RESOLVED: That this whole "post hoc" bureaucratic boondoggle be documented and sent to all our Michigan Senators and Representatives in the Congress of the United States.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, considered Resolutions 1 and 61 together. For Reference Committee and House action, see Resolution 1.

RESOLUTION 62

Auto Safety

Introduced by Kornelius Van Goor, MD

Whereas, the highway auto injury and death toll continues at an unreduced rate and is one of our major health hazards, and

Whereas, the 1968 Labor Day highway death toll was the greatest ever, and

Whereas, our federal government has misdirected attention to auto defects as an important cause of the highway slaughter, and

Whereas, our state government has made a start toward control of the drinking driver, and

Whereas, the medical profession is concerned with the treatment of the injured and the diseased, but also more importantly with the prevention of disease and injury, therefore be it

RESOLVED: That MSMS encourage the enactment of legislation which will:

1. More strictly enforce the existing laws relative to driving while drunk and impose more severe penalties for violation thereof.
2. Detect and prosecute the reckless or careless driver.
3. Provide for a more careful and appropriate interval examination of all drivers; and somehow accomplish legislation which will require physicians to report diseases or defects which might affect driving capability to our State Department with the direct result that re-evaluation of the driver may be accomplished.

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, recommended adoption of the resolution with the following amendments: Delete the third Whereas, and amend No. 3 in the resolved portion to read, "Provide for a more careful and appropriate interval examination of all drivers."

The Reference Committee also reaffirmed 1967 House of Delegates Resolution 51 on this subject.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 63

Direct Billing of Medicaid Group II (Medically Indigent) Patients

Introduced by Thomas Andrews, MD

Whereas, to preserve the direct patient-doctor payment relationship as the government plans future inclusion of increasingly large groups of employed patients in the medically indigent group, and

Whereas, many physicians want to maintain a direct financial relationship with their patient because they believe that the patient who has some responsibility in the payment mechanism, also may better recognize his responsibility to follow professional advice, and therefore benefit from medical care, and

Whereas, the Federal Title XIX Law provides direct payment to Medicaid Group II Patients at the option of the states; and that the State of Michigan does not now permit direct payment, therefore be it

RESOLVED: That the House of Delegates advise the State Department of Social Services to provide direct payment to Medicaid Group II Patients (Medically Indigent).

THE REFERENCE COMMITTEE on State and Federal Legislation, J. D. Fryfogle, MD, Chairman, amended the Resolved portion by adding at the end the words, "through legislative action if needed", and recommended its adoption as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 64

MDPAC

Introduced by Robert E. Rice, MD

Whereas, MDPAC is a voluntary, non-profit, unincorporated committee of individual physicians and others, and

Whereas, MDPAC has demonstrated its ability to encourage better candidates to seek and assist them to obtain office, and

Whereas, health legislation on a local, state and federal level continues to flood the deliberative halls and in an ever increasing tide, therefore be it

RESOLVED: That this House of Delegates commend the MDPAC Board of Directors for its efforts and many successes, and be it further

RESOLVED: That The Council be encouraged to actively support not only MDPAC but deserving local, state and national candidates as well.

THE REFERENCE COMMITTEE on Resolutions, R. C. Prophater, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 65

"Where We Stand"

Introduced by Harry A. Towsley, MD

Whereas, the monograph "Where We Stand" has been issued to the Delegates and officers of this Society, for two consecutive years, for their perusal and study, and

Whereas, the material therein has been provocative and stimulating in initiating constructive dialogue, and

Whereas, such a summarization of "medical positions" is necessary to our present and future deliberations, therefore be it

RESOLVED: That we commend the author, Mr. Hugh Brenneman, for this labor, and be it further

RESOLVED: That the House of Delegates authorize a yearly revision and updating of this monograph.

THE REFERENCE COMMITTEE on Miscellaneous Business, Marjorie Peebles Meyers, MD, Chairman, recommended adoption of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 66

Commendation to Claude L. Weston, MD

Introduced by James B. Blodgett, MD

Whereas, this House of Delegates of the Michigan State Medical Society is now convened in its 103rd Annual Session, and

Whereas, members of the House of Delegates, in accepting the responsibility of representing their constituent fellow physicians therein, perform a vital service to their Society and all of its individual members, and

Whereas, by giving of themselves, their valuable time and energies, delegates participate in the shaping of the course of our State Medical Society to the ultimate benefit of the profession and the people of Michigan it serves, and

Whereas, for nearly a full fourth of the 103 Annual Sessions of MSMS, without interruption, one delegate has faithfully and effectively represented his county medical society, making thereby a highly unusual and outstanding contribution to both his colleagues and the Society as a whole; therefore be it

RESOLVED: That this House of Delegates here and now, in deep appreciation and admiration, by rising acclamation, adopt this resolution commending and thanking Claude L. Weston, MD, delegate from Shiawassee County Medical Society, for his 26 consecutive years of service to this House of Delegates, his county society, the profession of medicine and the people of Michigan.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 67

Confidentiality of Michigan Medical Service Records

Introduced by Donald N. Sweeny, Jr., MD

Whereas, in the administration of Medicare, Michigan Blue Shield develops data and material relating not only to Part B of Medicare but also to other aspects of Blue Shield activity, and

Whereas, physicians' profiles and the data upon which they are based are illustrative of such composite data, and

Whereas, such data is received by Blue Shield from Michigan physicians in a confidential capacity; therefore be it

RESOLVED: That Blue Shield be urged to resist to the extent of its ability any effort by the Secretary of HEW to assert ownership of such data, and be it further

RESOLVED: That a copy of this resolution be transmitted to the Board of Trustees, American Medical Association and to the presidents of each state or territorial association for reference to his AMA Delegation.

THE REFERENCE COMMITTEE on Health Insurance and Medical Services, R. E. Rice, MD, Chairman, recommended approval of the resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 68

University of Michigan Hospital Centennial — 1969

Introduced by Harold F. Falls, MD

Whereas, the year 1969 will commemorate the one hundredth year of operation of the University Hospital of the University of Michigan Medical School, and

Whereas, the University Hospital has gained national and international recognition for its many contributions to medical science, organized medicine, medical education and services to patients of the State of Michigan and the Nation, and

Whereas, the University Hospital of the University of Michigan was the first of state-owned university hospitals to serve the patients and the doctors of any state in this Nation, and

Whereas, the University Hospital was recently recognized as one of the ten leading hospitals in the Nation, therefore be it

RESOLVED: That this House of Delegates to the MSMS extend its congratulations to the Board of Regents of the University of Michigan, to the past and current staff and administrative officers of the University Hospital for its past attainments and services to the people of the State of Michigan, and be it further

RESOLVED: That this House of Delegates, and MSMS extend its best wishes for the continuation of its outstanding service to the people of Michigan, and be it further

RESOLVED: That a copy of this commendation be sent to the officials of the University of Michigan.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration, and adopted the resolution by acclamation.

RESOLUTION 69

Advantages of Medical Practice in Michigan

Introduced by R. C. Prophater, MD

Whereas, there is a shortage of physicians in private practice in Michigan, and

Whereas, many more of the graduates of Michigan medical schools undoubtedly would decide to engage in private practice in Michigan if adequately informed of the opportunities available in this state; therefore be it

RESOLVED: That the Michigan State Medical Society encourage the various community agencies, such as chambers of commerce, to inform the students of the three Michigan medical schools of the advantages of medical practice in their areas.

THE HOUSE suspended the rules for the purpose of giving the resolution immediate consideration and adopted the resolution.

SPECIAL MEMBERSHIPS

THE REFERENCE COMMITTEE on Special Memberships, Arthur B. Levant, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the Secretary of MSMS in accordance with the Bylaws:

Life Memberships

Bay-Arenac-Iosco County — W. G. Gamble, Jr., MD; Otto F. Jens, MD; Mana Kessler, MD; Sabina Kessler-Frux, MD.

Calhoun County — John Robbert, MD.

Genesee County — James K. Sutherland, MD.

Ingham County — A. Edith Hall Kent, MD; Herbert K. Kent, MD; Milton Shaw, MD; Howard S. Willson, MD.

Jackson County — Ennis H. Corley, MD.

Kalamazoo County — William D. Irwin, MD; Alton E. Pullon, MD.

Kent County — Cornetta C. Moen, MD; William F. Reus, MD; Harold E. Veldman, MD.

Luce County — T. W. Thompson, MD.

Marquette-Alger County — Arthur L. Amolsch, MD.

Monroe County — Leonard C. Blakey, MD.

Oakland County — Ernest W. Bauer, MD; Ethel T. Calhoun, MD; Carl W. Dahlgren, MD; Loren C. Sheffield, MD; Loren C. Spademan, MD.

Ottawa County — Dirk C. Bloemendaal, MD; W. C. Kools, MD; Ralph Ten Have, MD.

Saginaw County — Suel A. Sheldon, MD; V. K. Volk, MD; Stuart Yntema, MD.

St. Clair County — John C. S. Battley, MD; J. Gilmore Kirker, MD.

Washtenaw County — Arthur C. Curtis, MD; Reed M. Nesbit, MD; Henry K. Ransom, MD; James L. Wilson, MD.

Wayne County — Harry E. August, MD; Louis L. Barnett, MD; A. Robert Bauer, MD; J. Keaner Bell, MD; Robert H. Berman, MD; John H. Boyd, MD; Harry L. Buller, MD; Howard A. Burrows, MD; Volney N. Butler, MD; Henry G. Chall, MD; Esther H. Dale, MD; Robert Durham, MD; Robert J. Elvidge, MD; Harold B. Fenech, MD; Russell F. Fenton, MD; Henry C. Galantowicz, MD; Ely W. Harelik, MD; Thomas J. Jamieson, MD; Stanley J. Joyce, MD; Raymond H. Koebel, MD; Maurice J. Kritchman, MD; Francis X. Krynicki, MD; J. Hugh Lewis, MD; J. Donald Mabley, MD; Rupert C. L. Markoe, MD; Pedro O. Martinez, MD; James J. McClendon, MD; Clarke M. McColl, MD; Clarence D. Moll, MD; Eugene A. Osius, MD; Harry A. Pearse, MD; Abraham S. Rogoff, MD; Frank M. Townsend, MD; Albert E. Vossler, MD; George L. Waldbott, MD; Edward A. Wishropp, MD; Wilford C. Wood, MD.

Retired Memberships

Allegan County — Lewis F. Brown, MD.

Bay-Arenac-Iosco County — Leslie A. Lambert, MD; Michael Medvesky, MD.

Calhoun County — Norman H. Amos, MD; Richard J. Campbell, MD; Stephen Fairbanks, MD.

Cass County — Rudolph I. Clary, MD.

Delta-Schoolcraft County — A. B. Bernier, MD.

Gratiot-Isabella-Clare County — William L. Harrigan, MD.

Ingham County — Roger Hanna, MD; Paul J. Ochsner, MD; Ralph H. Ruhnkorff, MD; Ralph Wadley, MD.

Kalamazoo County — Frederick M. Doyle, MD; Paul M. Fuller, MD; Robert C. Murdy, MD.

Kent County — Leon DeVel, MD.

Midland County — Harold H. Cay, MD.

Oakland County — Henry O. Coucke, MD; James T. Cheng, MD; Aben Hoekman, MD; Oliver Marcotte, MD; Theodore H. Pauli, MD.

Oceana County — Merle C. Wood, MD.

Saginaw County — Gerald L. Ackerman, MD; Harry M. Bishop, MD; Francis V. Kowals, MD; Harry G. Richter, MD.

Tuscola County — Willard W. Dickerson, MD.

Washtenaw County — Philip N. Brown, MD.

Wayne County — Leslie T. Colvin, MD; Charles C. Eades, MD; Harold H. Harris, MD; Paul V. O'Rourke, MD; Meshel Rice, MD.

Associate Memberships

The list of candidates for Associate Membership from Washtenaw County was reviewed. Since all candidates are eligible, no action is required by the House of Delegates inasmuch as they may become Associate Members of this Society upon application and certification by the secretary of their component medical society.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

CERTIFICATES OF COMMENDATION

Speaker James B. Blodgett, MD, presented the following Certificates of Commendation as authorized by the House of Delegates:

A. Fleming Barbour, MD, Genesee County —

"In recognition of his inspiring civic service in Flint for more than 25 years, especially with community programs for children, churches, the needy; and also for his excellent leadership in medical and specialty organizations."

Harry A. Clark, MD, Mason County —

"In recognition of many years of inspirational teaching as a professor at the Wayne State University Medical School; and in appreciation for continuing medical contributions to the people of Muskegon, and now Mason counties."

John M. Dorsey, MD, Wayne County —

"In recognition of his distinguished career as a psychiatrist, teacher and chairman of the Wayne State University Medical School Department of Psychiatry; and his many continuing contributions now to medicine, literature and education as the 'WSU University Professor,' "

Fred C. Sabin, MD, Marquette-Alger County —

"In recognition of his dedicated service as a member of the Northern Michigan University Board of Control and as a member of the Michigan State Board of Registration in Medicine; and as a prominent citizen of Marquette in professional, political and business circles."

Wilbur D. Towsley, MD, Midland County —

"In recognition of 45 years of distinguished service in Midland as a beloved family doctor; and for his unselfish assistance to many medical students, and also to many children and families in need."

MICHIGAN'S OUTSTANDING PHYSICIAN

James B. Blodgett, MD, Speaker, presented to Marjorie Peebles Meyers, MD, of Detroit, the following award as Michigan's Outstanding Physician of 1968:

"In recognition of a distinguished career as a Detroit internist, as an excellent clinical instructor for the Wayne State University Medical School, as a medical statesman for the Wayne County Medical Society and Michigan State Medical Society, and as a member of the Michigan delegation to the AMA House of Delegates; and also in recognition of inspiring service and leadership with many Michigan and Detroit health, welfare, cultural and educational organizations."

FIFTY YEAR AWARDS

President Bradley M. Harris, MD, presented the Fifty Year Award to the following:

Elden C. Baumgarten, MD, Wayne County
A. M. Giddings, MD, Calhoun County
Lloyd C. Harvie, MD, Saginaw County
Clyde K. Hasley, MD, Wayne County
M. S. Hurth, MD, Ingham County
Karm C. Kerwell, MD, Menominee County
Fred O. Lepley, MD, Wayne County
Milton D. Vokes, MD, Wayne County
Alfred H. Whittaker, MD, Wayne County

Fifty Year Awards subsequently were presented to the following persons who were not able to be present:

Wyman C. C. Cole, Sr., MD, Wayne County
Ray S. Dixon, MD, Wayne County
William E. Hilton, MD, Wayne County
Joseph A. Kasper, MD, Wayne County
Sol M. Lewis, MD, Oakland County
Welcome B. Lewis, MD, Calhoun County
Alton R. Marsh, MD, Wayne County
Arthur B. Norton, MD, Wayne County
Robert L. Novy, MD, Wayne County
Harold F. Raynor, MD, Wayne County
John B. Rieger, MD, Wayne County
Isaac S. Schembeck, MD, Wayne County
Edward F. Sladek, MD, Grand Traverse, Leelanau-Benzie County
James M. Stanton, MD, Wayne County
Garnet G. Stonehouse, MD, Kent County
William V. VanderVoort, MD, Calhoun County
T. P. Wickliffe, MD, now in Escondido, California

PRESIDENT'S AWARDS

President Bradley M. Harris, MD, presented awards "in recognition of and grateful appreciation for distinguished service to medicine" to:

Edwin DeYoung, MD, Birmingham — President, American Academy of Occupational Medicine
Francis P. Rhoades, MD, Detroit — President, Academy of Psychosomatic Medicine
John Hanlon, MD, Detroit — President, American Public Health Officers Association

SPECIAL AWARDS

The following AMA Certificates of Humanitarian Service were presented by AMA President-Elect Gerald D. Dorman, MD, to:

Daniel D. Chapman, MD, Owosso
J. Colin Elliott, MD, Buchanan
Joseph A. Grady, MD, Detroit
Seymour Krevsky, MD, Detroit
Armand M. LaSorsa, MD, Manistique
Donald Lipsey, MD, Durand
Adrian J. Neerken, MD, Kalamazoo
Leonard M. Pickering, MD, Southgate
Henry C. Scharnweber, MD, Midland
Roger A. Scholten, MD, Kalamazoo
Daniel B. White, MD, Rochester

"Presented by the American Medical Association in recognition of the meritorious service performed for the medical profession, the United States Government and the people of South Viet Nam by treating the ill and injured during his medical mission under the AMA's Volunteer Physicians for Viet Nam."

Speaker James B. Blodgett, MD, presented a Past Speaker's Key to former Speaker James J. Lightbody, MD.

EMPLOYEE AWARDS

Council Chairman Robert J. Mason, MD, presented the following employee awards as previously authorized by the House of Delegates:

Helen A. Schulte — 25 years of service
Robert J. Roney — 20 years of service

TRIBUTE TO DECEASED FORMER MEMBERS OF THE HOUSE OF DELEGATES

Secretary Kenneth H. Johnson, MD, read the following names and the members of the House arose and stood in silent tribute to their memory:

Charles L. Hess, MD, Bay County
Donald R. Wright, MD, Genesee County
I. W. Brown, MD, Kalamazoo County
J. R. McBride, MD, Lapeer County
H. D. Dykhuizen, MD, Muskegon County

C. T. Ekelund, MD, Oakland County
Oliver W. Lohr, MD, Saginaw County
Harry F. Dibble, MD, Wayne County
Crosby D. Eaton, MD, Wayne County
Joseph Hickey, MD, Wayne County

ELECTIONS

The following Officers and Councilors were elected:

President-Elect — Robert J. Mason, MD, Birmingham

Speaker — James B. Blodgett, MD, Detroit

Vice-Speaker — Vernon V. Bass, MD, Saginaw

Councilors (3-year terms) —
1st District: Milton R. Weed, MD, Grosse Pointe Park
7th District: John J. Coury, MD, Port Huron
8th District: A. Carl Stander, MD, Saginaw
10th District: Edward H. Rodda, MD, Bay City
12th District: William A. LeMire, MD, Escanaba
15th District: Sydney Scher, MD, Mount Clemens

Delegates to the American Medical Association
(January 1, 1969, to December 31, 1970)
Sidney Adler, MD, Detroit
George W. Slagle, MD, Battle Creek
Donald N. Sweeny, Jr., Detroit
Joseph A. Witter, MD, Highland Park

Alternate Delegates to the American Medical Association

(January 1, 1969, to December 31, 1970)
(in order of seniority)

James C. Danforth, Jr., MD, Detroit
Marjorie Peebles Meyers, MD, Detroit
John J. Coury, MD, Port Huron
Vernon V. Bass, MD, Saginaw

DIRECTORY

1968 MSMS House of Delegates

RECORD OF ATTENDANCE

OFFICERS

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Speaker:						
James B. Blodgett, MD, Detroit	X	X	X	X	X	X
Vice Speaker:						
Vernon V. Bass, MD, Saginaw	X	X	X	X	X	X
Immediate Past President:						
C. Allen Payne, MD, Grand Rapids	—	X	—	—	—	—
Secretary:						
Kenneth H. Johnson, MD, Lansing	X	X	X	X	X	X

DELEGATES

	Meetings					
	1st	2nd	3rd	4th	5th	6th
ALLEGAN						
Gerald A. VanderVoord, MD, Wayland	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE						
Frederick C. O'Dell, MD, Alpena	X	X	—	X	X	X
BARRY						
Robert J. Huebner, MD, Hastings	X	X	X	X	—	X
BAY-ARENAC-IOSCO						
Howard T. Knobloch, MD, Bay City	X	X	X	X	X	X
Robert C. Prophater, MD, Bay City	X	X	X	X	X	X
BERRIEN						
F. Alan Kennedy, MD, Benton Harbor	X	X	X	X	X	X
Frederick H. Lindenfeld, MD, Niles	—	X	X	X	X	X
BRANCH						
Robert M Leitch, MD, Union City; and	X	—	X	X	X	X
John D. Rick, MD, Coldwater	—	X	—	—	—	—
CALHOUN						
George T. Kelleher, MD, Battle Creek	X	X	X	X	X	X
Russell C. Rowan, MD, Albion	X	X	—	X	X	X
CASS						
Lowell D. Smith, MD, Cassopolis	—	—	—	X	X	X
CHIPPEWA-MACKINAC						
Donald D. Finlayson, MD, Sault Ste. Marie	X	X	X	X	X	X
CLINTON						
James M. Grost, MD, St. Johns	X	X	X	X	X	X
DELTA-SCHOOLCRAFT						
Donald N. Fitch, MD, Escanaba	X	X	X	X	X	X
DICKINSON-IRON						
Donald T. Anderson, MD, Kingsford	X	X	X	—	—	—
EATON						
Clayton O. Willits, MD, Charlotte	X	X	X	X	X	X
GENESEE						
John C. Benson, MD, Flint	—	—	X	X	X	X
Clifford W. Colwell, MD, Flint	X	X	X	X	X	—
Ernest P. Griffin, Jr., MD, Flint	X	X	X	X	X	X
Richard J. McMurray, MD, Flint	X	X	X	X	X	X
Lewis E. Simoni, MD, Flint	X	X	X	X	X	X
Philip K. Stevens, MD, Flint	X	X	X	X	X	X
Charles A. Thompson, MD, Flint	X	X	X	X	X	X
GOGEBIC						
Not represented						
GRAND TRAVERSE-LEELANAU-BENZIE						
Arthur F. Dundon, MD, Traverse City	X	X	X	X	—	—
Frank H. Power, MD, Traverse City	X	X	X	X	—	—
GRATIOT-ISABELLA-CLARE						
John M. Wood, MD, Mt. Pleasant	X	—	X	X	X	X
HILLSDALE						
Clark B. Smith, MD, Hillsdale	X	X	X	X	X	X
HOUGHTON-BARAGA-KEWEENAW						
Kenneth E. Rowe, MD, Calumet	X	X	X	X	X	X
HURON						
Charles W. Oakes, Jr., Harbor Beach	X	X	X	X	X	X
INGHAM						
Joseph R. Cipparone, MD, Lansing; and	X	X	X	X	—	—
John G. Wiegenstein, MD, Lansing	—	—	—	—	—	X
Herbert W. Harris, MD, Lansing	X	X	X	X	X	X
D. Bonta Hiscoe, MD, Lansing	X	X	X	X	X	X
Charles O. Long, Jr., MD, Lansing	X	X	X	X	X	X
Justin L. Sleight, MD, Lansing	X	X	X	X	X	—
Robert M. Stow, MD, Lansing	X	X	X	X	X	X
IONIA-MONTCALM						
Robert E. Rice, MD, Greenville	X	X	—	—	X	X
JACKSON						
Francis P. McQuillan, MD, Jackson	X	X	X	X	X	X
Harold L. Oster, MD, Jackson	X	X	X	X	X	X
KALAMAZOO						
Thomas E. Andrews, MD, Jackson	X	X	X	X	X	X
William D. Harrelson, MD, Kalamazoo	X	X	X	X	—	—
W. Kaye Locklin, MD, Kalamazoo	X	X	X	X	X	X
A John Neerken, MD, Kalamazoo	—	X	X	X	—	—
KENT						
Harvey M. Andre, MD, Grand Rapids	X	X	X	X	X	X
Noyes L. Avery, MD, Grand Rapids	X	X	X	X	X	—
Fred C. Brace, MD, Grand Rapids	X	X	X	X	X	X
Frederick S. Gillett, MD, Grand Rapids	X	X	—	X	X	X
William Haeck, Jr., MD, Grand Rapids	X	X	X	X	X	X
Jack Hoogerhyde, MD, Grand Rapids	X	X	X	X	X	X
Victor A. Notier, MD, Grand Rapids	X	X	X	X	X	X
Kornelius Van Goor, MD, Grand Rapids	X	X	X	X	X	X
LAPEER						
Charles E. Conaway, MD, Lapeer	X	X	X	X	X	X
LENAWEE						
Donato F. Sarapo, MD, Adrian	X	X	X	X	X	X
LIVINGSTON						
Edwin S. Woodworth, MD, Howell	—	X	—	X	X	X
LUCE						
Bernard G. Keizer, MD, Newberry	—	—	—	—	X	X
MACOMB						
Charles M. Ebner, MD, St. Clair Shores	X	X	X	X	X	X
Peter V. Kane, MD, Mt. Clemens	X	X	X	X	X	X
Sydney Scher, MD, Mt. Clemens	X	X	X	X	X	X
Edward G. Siegfried, MD, Mt. Clemens	X	X	X	X	X	X
MANISTEE						
Donald N. Schwing, MD, Manistee	—	—	X	—	—	—
MARQUETTE-ALGER						
George M. Wilson, Jr., MD, Marquette	X	X	X	X	X	X
MASON						
William F Sutter, MD, Ludington	X	X	X	X	—	—
MECOSTA-OSCEOLA-LAKE						
James L. Tyson, MD, Big Rapids	X	X	X	X	X	X
MENOMINEE						
Herman R. Brukardt, MD, Menominee	X	X	X	X	X	X
MIDLAND						
V. A. Marks, MD, Midland	X	X	X	X	X	X
MONROE						
S. Newton Kelso, Jr., MD, Monroe	X	X	X	X	X	X
MUSKEGON						
Howard V. Sanden, MD, Muskegon; and	X	X	X	—	—	—
Robert Swedenburg, MD, Muskegon	—	—	—	X	X	X
Norbert W. Scholle, MD, Muskegon	X	X	—	X	X	X
Donald P. Stratton, MD, Muskegon	X	X	X	X	X	X
NEWAYGO						
J. Paul Klein, MD, Fremont	X	X	—	X	X	X
NORTH CENTRAL						
Charles L. Oppy, MD, Roscommon	X	X	X	X	X	X
NORTHERN MICHIGAN						
Not represented						
OAKLAND						
Bruce D. Bauer, MD, Berkley	X	X	X	X	X	X
Robert M. Bookmyer, MD, Birmingham	X	—	—	—	—	—
Arnold L. Brown, MD, Pontiac	X	X	X	X	X	X
Peter A. Duhamel, MD, Rochester	—	X	X	X	X	—
Edward E. Elder, Jr., MD, Pontiac	X	X	X	X	X	X
Harold A. Furlong, MD, Pontiac	X	X	X	X	X	X
Richard R. Galpin, MD, Birmingham	X	X	X	X	X	—

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Worth W. Henderson, MD, Royal Oak	—	—	X	X	X	X
Paul T Lahti, MD, Royal Oak	X	X	X	X	X	X
John H. McLaughlin, MD, Birmingham	X	X	X	X	X	X
James R. Quinn, Jr., MD, Pontiac	X	X	—	X	X	X
James A. Read, MD, Birmingham	—	X	X	X	X	X
F. Michael Sheridan, MD, Royal Oak	X	X	—	X	X	X
OCEANA						
John J. Vrbanac MD, Hart	—	X	X	X	X	X
ONTONAGON						
Not represented						
OTTAWA						
William Rottschaefer, MD, Holland	X	X	X	X	X	X
SAGINAW						
Jack L. Barry, MD, Saginaw	—	X	X	X	X	X
Roy J. Gerard, MD, Saginaw	X	X	—	X	X	X
Duane B. Heilbronn, MD, Saginaw	X	X	X	X	X	X
Robert J. Toteff, MD, Saginaw; and	X	X	—	X	X	X
William A. DeYoung, MD, Saginaw	—	—	X	—	—	—
ST. CLAIR						
Alexander E. Hlivko, MD, St. Clair	X	X	X	X	—	—
James H. Tisdel, MD, Port Huron	X	X	X	X	X	—
ST. JOSEPH						
Stanley C. Penzotti, MD, Three Rivers	X	X	X	X	X	X
SANILAC						
Keate T. McGunegle, MD, Sandusky	X	X	X	X	X	X
SHIAWASSEE						
Claude L. Weston, MD, Owosso	X	X	X	X	X	X
TUSCOLA						
Herbert Lee Nigg, MD, Caro	X	X	X	X	X	X
VAN BUREN						
David J. Millard, MD, Paw Paw	X	X	X	X	X	X
WASHTENAW						
Clarence E. Crook, MD, Ann Arbor	X	X	X	X	—	X
Stuart M. Gould, Jr., MD, Ann Arbor	X	X	X	X	X	X
John W. Henderson, MD, Ann Arbor	X	X	X	X	X	X
John E. Magielski, MD, Ann Arbor; and	X	X	X	X	—	—
Robert S. Ideson, II, MD, Ann Arbor	—	—	—	—	—	X
Beverly C Payne, MD, Ann Arbor	X	X	X	X	X	X
Henry A. Scovill, MD, Ypsilanti	X	X	X	X	X	X
Harry A. Towsley, MD, Ann Arbor	X	X	X	X	X	X
Howard R. Williams, MD, Ann Arbor	X	X	X	X	X	X
WAYNE						
Sidney Adler, MD, Detroit	—	X	X	X	—	—
Robert D. Allaben, MD, Detroit	X	X	X	X	X	X
Raymond J. Barrett, MD, Detroit	X	—	X	—	—	—
Frank B. Bicknell, MD. Detroit	—	—	X	—	—	—
Alexander Blain, III, MD, Detroit	X	X	X	X	—	—
James B. Blodgett, MD, Detroit	—	—	—	—	—	—
William L. Brosius, MD, Rochester	X	X	X	X	X	X
Brock E. Brush, MD, Detroit	X	X	X	X	X	X
Fred E. Caumartin, MD, Detroit	X	X	X	X	X	X
Ned I. Chalat, MD, Detroit	—	—	X	X	X	X
Sidney E. Chapin, MD, Dearborn	X	X	X	X	X	X
Paul J. Connolly, MD, Detroit	X	X	X	X	X	X
James C. Danforth, Jr., MD, Grosse Pte. Wds.	X	X	X	X	X	X
Charles E. Darling, MD, Detroit	—	X	X	X	X	X
Henry M. Domzalski, MD, Detroit	X	X	X	X	X	X
Paul R Dumke, MD, Detroit	X	X	X	X	X	X
Laurel S. Eno, MD, Detroit	X	X	X	X	X	X
George S. Fisher, MD, Detroit	X	X	X	X	X	X
Thomas M. Flake, MD, Detroit	X	X	X	X	X	X
C. Jackson France, MD, Detroit	X	X	X	X	X	X
Eugene L. Freitas, MD, Detroit	X	X	X	X	X	X
James D. Fryfogle, MD, Southfield	X	X	X	X	X	X
Thomas Ganos, MD, Allen Park	—	—	X	X	X	X
Alfred Golden, MD, Huntington Woods	X	X	X	—	—	—
Robert H. Hamburg, MD, Detroit	X	X	—	—	—	—
Louis E. Heideman, MD, Detroit	—	—	—	X	X	X
Alexander H. Hirschfeld, MD, Detroit; and	X	X	X	X	—	X
Robert B. Clarke, MD, Detroit	—	—	—	—	X	—
Homer A. Howes, MD, Detroit	X	X	X	X	X	X
H. Ross Hume, MD, Detroit	X	X	X	X	X	X
Eli J. Igna, MD, Detroit	X	X	X	X	X	X
Benjamin Jeffries, MD, Harper Woods	X	X	—	X	X	X
Loyal W. Jodar, MD, Grosse Pte.	X	X	X	—	—	—
Harry Y. Kasabach, MD, Detroit	X	X	X	X	X	X
James M. Kennary, MD, Detroit	X	X	X	X	X	X
Luther R. Leader, MD, Royal Oak	X	X	X	X	X	—
Arthur B. Levant, MD, Detroit	X	X	X	X	X	X
Robert E. McKnight, MD, Southfield	—	—	—	—	—	—
Marjorie Peebles Meyers, MD, Detroit	X	X	X	X	—	—
Harold V Morley, MD, Detroit	X	X	X	X	X	X
John W. Moses, MD, Detroit	X	X	X	X	X	X
John W. Moynihan, MD, Dearborn	—	—	X	—	—	—
Ralph H. Pino, MD, Plymouth	X	X	X	X	X	X
George L. Reno, MD, Detroit	X	X	X	X	X	X
Francis P. Rhoades, MD, Detroit	X	X	X	X	X	X
John W. Sigler, MD, Detroit	X	X	X	X	X	X
John G. Slevin, MD, Grosse Pte. Park	X	X	X	X	X	X
Homer M. Smathers, MD, Detroit	X	X	X	X	X	X
Carl J. Sprunk, MD, Melvindale	X	—	X	—	X	X
Donald N. Sweeny, Jr., MD, Detroit	X	X	X	X	X	X
Edward J. Tallant, MD, Detroit	X	X	X	X	X	X
Frank B. Walker, MD, Grosse Pte. Park	X	X	X	X	X	X
Frederick Weissman, MD, Southfield	—	—	X	—	—	—
Alfred H. Whittaker, MD, Grosse Pointe; and	X	—	—	—	—	—
Earl C. Long, MD, Detroit	—	—	—	—	—	X
Joseph A. Witter, MD, Highland Park	X	X	X	X	X	X
William J. Yott, MD, Detroit	X	X	X	X	X	X
Louis R. Zako, MD, Allen Park	—	—	—	—	—	—
WEXFORD-MISSAUKEE						
Dennis E. Van Alst, MD, Cadillac	X	X	X	X	X	X
SECTION DELEGATES						
ALLERGY AND APPLIED IMMUNOLOGY						
James A McLean, MD, Ann Arbor	X	X	X	—	—	—
ANESTHESIOLOGY						
Ralph F. Askam, MD, Muskegon	—	X	X	X	X	X
DERTAMOLOGY						
Robert J. Schoenfeld, MD, Birmingham	X	—	X	—	—	—
GASTROENTEROLOGY						
Not represented						
GENERAL PRACTICE						
Douglas A. Haddock, Jr., MD, Kalamazoo	X	X	X	X	X	X
INTERNAL MEDICINE						
Not represented						
NEUROLOGICAL SURGERY						
H. Harvey Gass, MD, Detroit	—	X	X	—	—	—
OBSTETRICS-GYNECOLOGY						
Howard R. Williams, MD, Ann Arbor	—	—	—	—	—	—
OCCUPATIONAL MEDICINE						
Not represented						
OPHTHALMOLOGY						
Not represented						
OTOLARYNGOLOGY						
Not represented						
ORTHOPEDIC SURGERY						
Edward F. Kickham, MD, Saginaw	—	X	—	—	—	—
PATHOLOGY						
John R. McDonald, MD, Detroit	—	—	X	X	X	—
PEDIATRICS						
George L. Blum, MD, Detroit	X	—	—	—	—	—
PHYSICAL MEDICINE						
Not represented						
PLASTIC SURGERY						
Edward J. Hill, Jr., MD, Detroit	—	—	—	—	—	—
PROCTOLOGY						
Donald J. Pearson, MD, Battle Creek	X	X	X	X	X	X
PHYCHIATRY & NEUROLOGY						
Robert B. Clarke, MD, Detroit	X	X	—	—	X	—
PUBLIC HEALTH & PREVENTIVE MEDICINE						
G. Frederick Moench, MD, Sanford	X	X	X	X	X	X
RADIOLOGY						
Benjamin R. VanZwalenburg, MD, Grand Rapids	X	X	X	—	—	—
SURGERY						
John W. Derr, MD, Detroit	X	—	—	—	—	—
THORACIC SURGERY						
Not represented						
UROLOGY						
Robert C. Thumann, MD, Grosse Pte. Woods	X	X	—	X	X	X
MEDICAL STUDENTS						
SAMA						
Rosemarie Lucianin	X	X	X	X	X	—
UNIVERSITY OF MICHIGAN						
Joseph Luciano	X	—	—	—	—	—
Joel Morganroth	X	X	X	—	—	—
Charles Artinian	X	X	X	X	—	—
WAYNE STATE UNIVERSITY						
David Priver	X	X	X	X	X	X
Charles Dumanois	—	X	X	—	—	—

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E. P. Griffin, Jr., MD, Genesee

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R. M. Stow, MD, Ingham
R. R. Galpin, MD, Oakland
P. V. Kane, MD, Macomb

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J. R. Franck, Jr., MD, Wakefield

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D. T. Anderson, MD, Dickinson-Iron

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B. M. Harris, MD, Ypsilanti

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John M. Wood, MD, Gratiot-Isabella-Clare
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Jack Hoogerhyde, MD, Kent
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F. H. Power, MD, Grand Traverse-Leelanau-Benzie
Sidney Scher, MD, Macomb

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C. A. Payne, MD, Grand Rapids

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H. A. Furlong, MD, Oakland
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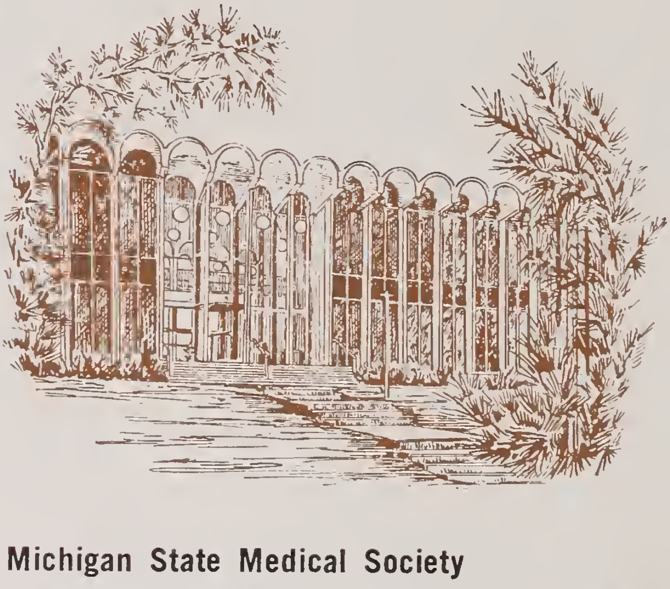
F. E. Caumartin, MD, Wayne
E. G. Siegfried, MD, Macomb

PARLIAMENTARIAN

Mr. A. Stewart Kerr

MICHIGAN STATE MEDICAL SOCIETY
FUTURE ANNUAL SESSION DATES

1969-Detroit, September 28-October 3
1970-Detroit, September 20-25
1971-Grand Rapids, October 3-8



Michigan State Medical Society
The professional association of Michigan doctors of medicine
120 West Saginaw
East Lansing, Michigan 48823

NONCIRCULATING

PERIODICAL

NONCIRCULATING

PERIODICAL